

CASEREVIEW

8017 Sitka Street
Fort Worth, TX 76137
Phone: 817-226-6328
Fax: 817-612-6558

Notice of Independent Review Decision

[Date notice sent to all parties]: November 17, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L4-SA Lumbar Medical Branch Block with Marcaine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This physician is Board Certified in Physical Medicine and Rehabilitation with over 18 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx. She started having lower back pain which steadily increased through the day. She was initially diagnosed with Lumbar Sprain and Right Lumbar Sciatica. She was taken off work and prescribed Robaxin, Tramadol and Methylprednisolone 4 mg Dosepak. X-rays of the lumbar spine on 11/13/12 were negative. She sought chiropractic care which did not help.

On November 27, 2012, the claimant presented with moderate aching and shooting lumbar pain. The pain was made worse by waling and standing for prolonged periods of time. She also had referred pain to the right leg. Pain level was rated 7/10. On physical examination no spasm was present. Pain to palpation over the lower lumbar spine. ROM was limited. SLR was positive on the right at 45 degrees, negative on the left. Pain to palpation present over the right sacroiliac joint. Left knee reflex was 2+/4, left ankle reflex was 1+/4. Right

knee reflex was 2+/4 and right ankle reflex was 0/4. Light touch sensation was normal and normal strength in the leg. Plan: MRI recommended.

On December 3, 2012, MRI of the Lumbar Spine, Impression: 1. Degenerative disc signal at the L5-S1 level with diminished T2 signal compatible with desiccation. There is minimal height loss at this level. 2. Asymmetric osteophyte formation and disc protrusion slightly encroaches the anterior subarachnoid space on the right at the L5-S1 level. This may rise to the level of the small disc extrusion, but appears to be more broad-based. This appears to be posteriorly displaced and contact the right S1 nerve root within the lateral recess. Neural foraminal encroachment is not evident. The left S1 nerve root is closely approached by the disc protrusion, but does not appear to be displaced. There are no other signs of acute abnormality.

On December 6, 2012, the claimant presented who indicated she had radicular pain to the right leg with loss of right ankle reflex and MRI showing disc protrusion contacting right S1 nerve. She was instructed to continue Robaxin, Tramadol and Sombra gel. Allergic to ASA therefore unable to use nsaid. Referred for ESI.

On February 4, 2013, the claimant presented with lower back pain on the right radiating to the right buttock down to right knee. Sudden lower back pain with bending, while at work, worsens with sitting, driving, walking and during exercise. Relieved by movement, frequent position changes while sitting, and with medications. On physical examination the lumbosacral spine exhibited tenderness on palpation of the spinous process. No muscle spasm. SLR was negative. Lumbar extension test was positive. Tactile stimulation showed a reduced sensory response on the sole of the right foot and on the right posterior leg. No LE weakness was observed. The right ankle jerk was absent. Assessment: Sacral radiculopathy at S1 due to L5-S1 disc herniation. Plan: Rt. S1 SNB.

On March 6, 2013, indicated that she did not respond to the S1 SNB and continued to have significant back and right leg pain. She was referred to a surgeon.

On August 26, 2013, the claimant presented with an increase in pain. She had completed PT which she indicated provided no relief. She reported constant aching to the right side of the low back that radiated into the right buttock and down the back of the right leg usually to the knee, but sometimes the ankle. Current medications: Ibuprofen, Norco, Robaxin and Tylenol Rapid Release Gelcap. Plan: Right L5/S1 Microdiscectomy.

09/19/13: Operative Report. Postoperative Diagnosis: Right L5-S1 herniated disk causing lower extremity radiculopathy. Procedures: 1. Right L5-S1 hemilaminectomy, medial facetectomy, and microdiscectomy. 2. Use of the operating microscope.

On October 23, 2013, the claimant presented 6 weeks post op. She stated she was not any better and still had aching across all of the lower back with radiation into her right hip and down the lateral part of her right leg. Plan: Start physical therapy. If no improvement, may require a lumbar MRI or right SI joint injection.

On February 21, 2014, the claimant presented with continued low back and right leg pain. She had 2 more days of PT left and reported it had not been helping with pain. She reported taking Ibuprofen 3 times a day. On physical examination she had tenderness on palpation. SLR was negative. Reverse SLR was limited on the right due to stiffness. No sensory abnormalities were noted. Right ankle jerk was 1. Assessment: 1. Lumbar radiculopathy. 2. Postlaminectomy syndrome. Plan: MRI.

On February 28, 2014, MRI Lumbar Spine, Impression: 1. Focal large right-sided disk herniation at L5-S1. 2. Otherwise unremarkable.

On March 28, 2014, the claimant presented to NP with continued pain. discussed several options of surgery and the claimant wished to proceed with a L5-S1 PLIF.

On September 8, 2014, the claimant presented 5 months S/P redo PLIF. She was in PT which she felt was not helping. She still had pain across her low back into her right lateral hip and down the right leg to the top of her foot. She was not much better following surgery. On physical examination a Patrick-Fabere test was positive at the right side of the sacroiliac joint. Dorsiflexion was not decreased on the right. There was no weakness of the right quadriceps muscles on the right. Right plantar flexion strength was normal. There was normal right knee and ankle jerk. There was positive right thigh thrust and right fortin finger test. Assessment: Evidence of right degenerative sacroilitis on clinical exam. Plan: Refer for a series of SI joint injections/rhizotomy.

On September 24, 2014, the claimant presented with lower back pain on the right. On examination there was tenderness on palpation of the spinous process and of the transverse process bilaterally-right side worse. The posterior aspect of the coccyx exhibited no tenderness on palpation. The gluteus medius muscle showed tenderness on palpation on the right. Reflexes were normal. Xray of the lumbosacral spine with anteroposterior and lateral views was performed and showed L5-S1 Intervertebral spacer in place. Assessment: 1. Lumbar facet syndrome. 2. Lumbar radiculopathy-S/P L5-S1 PLIF. Plan: She is S/P L5-S1 PLIF with moderate right sided s joint pain and right gluteus medius pain. She has been through an extensive course of PT. She isn't responding to the oral medications. She has no evidence of radiculopathy on exam. I will proceed with diagnostic right lumbar MBB's with Marcaine. If she responds to the diagnostic block then I will consider RF Neurotomy.

On October 3, 2014, UR. Rationale for Denial: female who had an L5/S1 fusion. She has right lumbar tenderness, reduced extension, no neuro findings. The medial branch block is denied as the nerves innervate the fused level, L5/S1, which is a contraindication for doing this procedure as per ODG criteria.

On October 21, 2014, UR. Rationale for Denial: The official disability guidelines Low Back (updated 08/22/14) do not support Facet joint diagnostic blocks (injections). This claimant has had discectomy and fusion at L5/S1 and has a recurrent protruded disc effacing S1. The patient has had a block in the past that was not effective in relieving her pain. She does not meet criteria for a block as she has had surgery to the same area and she did not benefit from a previous block.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Denial of Medial Branch Blocks L4 to S1 is UPHeld/AGREED UPON given lack of documented objective findings suggestive of facet mediated pain at the targeted levels L4-5 and L5-S1 with no tenderness noted specifically at these levels and no documented provocative maneuvers (such as compression, facet loading, extension/rotation). There is also objective evidence of other possible pain generators, including the right Sacroiliac joint. There is also surgical fusion of one of the requested levels, L5-S1, thereby eliminating the pathophysiology of movement as an irritant to these joints. Furthermore, there is no documentation of more recent conservative measures, including activity modification and compliance with a home exercise program, prior to proceeding to additional invasive procedures. Therefore, the request for Right L4-SA Lumbar Medical Branch Block with Marcaine is denied.

Per ODG:

Criteria for the use of diagnostic blocks for facet “mediated” pain:

Clinical presentation should be consistent with [facet joint pain, signs & symptoms](#).

1. One set of diagnostic medial branch blocks is required with a response of $\geq 70\%$. The pain response should last at least 2 hours for Lidocaine.
2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.
3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).
5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.
6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.
7. Opioids should not be given as a “sedative” during the procedure.
8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.
9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.
10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. ([Resnick, 2005](#))

11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. ([Franklin, 2008](#))]

Facet joint
medial branch
blocks
(therapeutic
injections)

Not recommended except as a diagnostic tool. Minimal evidence for treatment.

Pain Physician 2005: In 2005 *Pain Physician* published an article that stated that there was moderate evidence for the use of lumbar medial branch blocks for the treatment of chronic lumbar spinal pain. ([Boswell, 2005](#)) This was supported by one study. ([Manchikanti, 2001](#)) Patients either received a local anesthetic or a local anesthetic with methyl prednisolone. All blocks included Sarapin. Sixty percent of the patients overall underwent seven or more procedures over the 2½ year study period (8.4 ± 0.31 over 13 to 32 months). There were more procedures recorded for the group that received corticosteroids than those that did not (301 vs. 210, respectively). [“Moderate evidence” is a definition of the quality of evidence to support a treatment outcome according to *Pain Physician*.] The average relief per procedure was 11.9 ± 3.7 weeks.

Pain Physician 2007: This review included an additional randomized controlled trial. ([Manchikanti2, 2007](#)) Controlled blocks with local anesthetic were used for the diagnosis (80% reduction of pain required). Four study groups were assigned with 15 patients in each group: (1) bupivacaine only; (2) bupivacaine plus Sarapin; (3) bupivacaine plus steroid; and (4) bupivacaine, steroid and Sarapin. There was no placebo group. Doses of 1-2ml were utilized. The average number of treatments was 3.7 and there was no significant difference in number of procedures noted between the steroid and non-steroid group. Long-term improvement was only thought to be possible with repeat interventions. All groups were significantly improved from baseline (a final Numeric Rating Scale score in a range from 3.5 to 3.9 for each group). Significant improvement occurred in the Oswestry score from baseline in all groups, but there was also no significant difference between the groups. There was no significant difference in opioid intake or employment status. There was no explanation posited of why there was no difference in results between the steroid and non-steroid groups. This study was considered positive for both short- and long-term relief, although, as noted, repeated injections were required for a long-term effect. Based on the inclusion of this study the overall conclusion was changed to suggest that the evidence for therapeutic medial branch blocks was moderate for both short- and long-term pain relief. ([Boswell2, 2007](#)) Psychiatric comorbidity is associated with substantially diminished pain relief after a medial branch block injection performed with steroid at one-month follow-up. These findings illustrate the importance of assessing comorbid psychopathology as part of a spine care evaluation. ([Wasan, 2009](#)) The use of the blocks for diagnostic purposes is discussed in [Facet joint diagnostic blocks](#) (injections). See also [Facet joint intra-articular injections](#) (therapeutic blocks).

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**