

Health Decisions, Inc.
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Notice of Independent Review Decision

October 20, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L5-S1 Lumbar Medial Branch Block

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

American Board of Orthopaedic Surgery certified physician with over 13 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 that slipped and fell on a hard floor at work on xx/xx/xx. She reported back pain that radiated into the bilateral upper extremities. She has had 1 ESI, lumbar lysis of adhesions and at-home PT, none of which has given sustained pain relief.

06-30-09: Orthopedic Report. The claimant c/o lower lumbar pain and some back spasms that she rates 6/10. On exam, there is some pain on palpation of right lower lumbar region. Impression: 1. Herniated nucleus pulposus at C5-C6 with some myopathy. 2. Annular tear at L5-S1. Plan of TX: 1. Recommend anterior cervical discectomy and fusion of C5-C6. 2. Post-op to begin PT.

01-25-10: Orthopedic Report. The claimant c/o numbness in her hands bilaterally. Otherwise no change in previous sx's. On exam, SLR elicits back pain

only. Her motor strength and sensation are intact in her lower extremities and her reflexes are 2+ and symmetric. Plan of TX: Review claimant's medication.

08-06-10: Orthopedic Report. The claimant c/o constant low back pain that occasionally radiates down both of her lower extremities, more on the left. She rates her pain as 9/10. On exam, lumbar spine continues to have tenderness in her lower lumbar region with decreased ROM with flexion and extension limited by pain. Plan of TX: 1. Recommend lumbar ESI, however, claimant wishes to wait. 2. Refill medication.

11-16-10: Orthopedic Report. Since the claimant's last visit she has been participating in at-home PT which is providing temporary relief. She c/o low back pain that is constant and has difficulty with side-to-side movement, soreness and stiffness. The pain radiates into both lower extremities, worse on left. On exam, lumbar spine has tenderness in the mid to lower region and decreased ROM. SLR elicits back and left leg pain. Plan of TX: 1. Recommend lumbar ESI.

02-08-11: Orthopedic Report. The claimant states she is interested in discussing lumbar ESI to help with her low back and leg sx's. On exam, lumbar spine has severe tenderness in the mid to lower region with decreased ROM. She has positive SLR on left only. She has very little paresthesia's in the lateral aspect of both lower extremities. Plan of TX: The claimant has exhausted PT and oral NSAIDS with temporary relief. On exam the finding was radiculitis in her left lower extremity. MRI of her lumbar spine reveals an annular tear at the L5-S1 level. The claimant is suffering from some kind of chemical radiculitis following her annular tear at the L5-S1 level. It is believed that there is leaking of internal disk proteins onto sensitive neurological tissues. The protein is an irritant and, therefore it creates pain when in contact with the nerve causing the claimant's sx's in her LLE and she would benefit from lumbar ESI.

03-17-11: Operative Report. Pre-Op Dx: Lumbar. Post-Op Dx: Lumbar annular tear L5-S1. Procedures: 1. Lumbar ESI. 2. Lumbar lysis of adhesions. 3. Interpretation of lumbar epidurogram. 4. Fluoroscopic localization of needle, lumbar.

03-28-11: Orthopedic Report. The claimant states she noticed some relief after ESI, but has had discomfort for a few days. She c/o low back pain with discomfort with side-to-side movement, soreness and stiffness. She states she has occasional pain that radiates down both LE. On exam, claimant has severe tenderness to her mid to lower lumbar region with decreased ROM. Positive SLR on the left. Plan of TX: Start post-injection PT and she remains symptomatic.

08-25-11: Orthopedic Report. The claimant c/o pain that radiates to her hips bilaterally. Plan of TX: Candidate for additional injection.

11-11-11: Orthopedic Report. The claimant states her first ESI gave her approximately 6 months of relief and then her pain then slowly returned. Plan of TX: The claimant has exhausted PT and oral anti-inflammatories. On exam,

radiculities of the LLE and suffering from some chemical radiculitis.

12-19-11: Operative Report. Pre-Op DX: Lumbar. Post-Op DX: Lumbar radiculopathy. Procedures: 1. Lumbar ESI, 2. Lumbar lysis of adhesions, 3. Interpretation of lumbar epidurogram, 4. Fluoroscopic localization of needle, lumbar.

01-03-12: Orthopedic Report. The claimant c/o spasms in her low back. Plan of TX: Recommend post-injection PT.

01-17-12: Initial Evaluation. The claimant c/o LBP in midline on both sides that radiates to left. She states she is weak in LLE and has muscle spasms. Spine ROM: Active trunk flexion 18 inches above the floor, active trunk extension refused d/t pain, active right trunk side bending 3 inches above fibular head and active left trunk side bending 2 inches above fibular head. Strength and tone: Lumbar/abdominals: Elevation of pelvis 3/5, 3/5 core strength difficult to test d/t pain and guarding. Inspection and palpation: Thoracic/lumbar muscles palpation: Tender left paralumbar and tender right. Lumbar spine inspection: Decreased lumbar lordosis and pt stands in flexed trunk posture.

02-13-12: Orthopedic Report. The claimant still c/o lumbar pain with numbness into her left leg.

04-11-12: Orthopedic Report. The claimant on exam has annular tearing and believe she is experiencing some axial mechanical back pain in nature.

06-15-12: Orthopedic Report. The claimant on exam continued to have paresthesia's in the lateral aspects of both lower extremities, into her heels. Plan of TX: Recommend ESI and TENS unit.

09-13-12: Orthopedic Report. The claimant on exam motor strength was weakened in both LE.

04-05-13: Office Visit Report. Claimant taking Lorcet and Soma. Musculoskeletal: Pt has hx of muscular weakness. On palpation, tenderness in spinous, thoracic and lumbar area. Bilateral great trochanter and SI joint tenderness. ROM active limitations: Rotation with mild restriction and lateral flexion with moderate restriction. Muscle testing: Left hip abduction 4/5, left knee extensor 4/5, left knee flexion 4/5 and bilateral patella reflex 2/4. L5 is bilaterally decreased. SLR: Right – back pain only, left – posterior thigh pain.

08-13-13: Office Visit Report. On exam the claimant has left hip adductors 4/5 and Fabere's test positive on left. Gait is antalgic and compensated. Tenderness noted in spinous, thoracic and lumbar region. Left great trochanter/left SI joint/buttock painful. The claimant has severe muscle spasm. Rotation with mild restriction and Achilles reflex bilaterally ¼. Positive Gaenslen's positive on left. She was given Baclofen.

11-07-13: Office Visit Report. The claimant presents with 10/10 radiating pain into her left hip and numbness in her left foot. She was given Tizanidine.

11-18-13: Office Visit Report. The claimant presents with lumbar region pain with numbness and tingling radiating down her LLE.

01-17-14: Orthopedic Report. The claimant c/o back pain with associated stiffness in the morning.

04-22-14: Orthopedic Report. The claimant c/o constant back pain and muscle spasms radiating to LLE. On exam, lower extremity motor strength is more or less weakened. Plan of TX: Recommend setting pt up with pain management specialist.

06-24-14: Orthopedic Report. The claimant states that the effects of the ESI started to wear off in 2/2014. She c/o having pain and swelling in LLE and her back pain doesn't allow her to do ADL's. Plan of TX: Recommend getting an up-to-date MRI.

07-23-14: MRI Lumbar Spine without Contrast. Impression: At the L5/S1 level, there is a left paracentral annular tear.

08-08-14: Orthopedic Report. The claimant c/o primarily of axial mechanical back pain and right hip pain. On exam, her right lower lumbar region has limited ROM and has positive Kemp sign. Impression: Right lumbar facet pain, right L5 and S1. Plan of TX: Recommend a medial branch block at her right L5 and S1 region and if does well a radiofrequency ablation to those levels tested.

08-18-14: URA. Rationale: The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The Official Disability Guidelines state that facet medial joint branch blocks are not recommended except as a diagnostic tool as there is minimal evidence for treatment. Clinical presentation should be consistent with facet joint pain signs and symptoms. It should be limited to patients with low back pain that is non-radicular and there should be documentation of failure of conservative treatment including home exercise, physical therapy and NSAIDS prior to the procedure for at least 4-6 weeks. There is a lack of documentation regarding failure of conservative treatment. Based on the clinical information submitted for review, the patient had tenderness in her right lower lumbar region with limited range of motion with extension and a positive Kemp sign. However, there are no significant functional deficits to indicate the need for a medial branch block in the lumbar region. The patient was also noted to have a positive straight leg raise which would not be supportive of facet mediated pain. Without evidence of significant functional deficits in the lumbar region and documented evidence of failed conservative treatment, a medial branch block would not be supported. Given the above, the request is non-certified.

09-09-14: URA. Rationale: The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. Current medications were not provided within the submitted medical records. Surgical history was not documented within the submitted medical records. A previous review of this request was non-certified due to no documentation of recent failed evidence-based conservative care coupled with documentation of possible radicular findings. The Official Disability Guidelines recommend no more than 1 set of medial branch blocks prior to facet neurotomies. Neurotomy is chosen as an option for treatment. Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed level. The criteria for the use of diagnostic blocks as recommended by the guidelines include: 1 set of diagnostic medial branch blocks is required with a response of greater than 70 percent; the pain response should last at least 2 hours for lidocaine; limited to patients with low back pain that is non-radicular and at no more than two levels bilaterally; there is documentation of failure of conservative treatment (including home exercise, PT and NSAIDS) prior to the procedure for at least 4 to 6 weeks. Within the submitted documentation, there was evidence that the patient did not have signs of radicular findings, as evidenced by positive Kemp's testing, 2+ deep tendon reflexes, intact motor strength and intact sensory testing. However, there was no presented documentation to show that the patient had a failure of conservative treatment prior to the request for at least 4 to 6 weeks. Without further documentation that the patient has failed conservative treatments prior to the request for at least 4 to 6 weeks, the request at this time cannot be supported by the guidelines. As such, the request is non-certified.

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

The previous adverse determinations are upheld. The patient is not indicated for a right L5-S1 lumbar medial branch block. Medial branch blocks should be limited to patients with non-radicular lower back who have failed conservative treatment. The patient's back pain is associated with radicular symptoms in the left leg, including pain, numbness, and tingling. She has a known disk herniation at L5-S1, which is the primary pain generator for this patient. The medical record does not document 4-6 weeks conservative care consisting of physical therapy and medication. The patient does not meet criteria for a medial branch block. Therefore, the request for Right L5-S1 Lumbar Medial Branch Block is non-certified.

Per ODG:

Recommend diagnostic criteria below. Diagnostic blocks are required as there are no findings on history, physical or imaging studies that consistently aid in making this diagnosis. Controlled comparative blocks have been suggested due to the high false-positive rates (17% to 47% in the lumbar spine), but the use of this technique has not been shown to be cost-effective or to prevent a false-positive response to a facet neurotomy. ([Bogduk, 2005](#)) ([Cohen 2007](#)) ([Bogduk, 2000](#))

([Cohen2, 2007](#)) ([Mancchukonda 2007](#)) ([Dreyfuss 2000](#)) ([Manchikanti 2003](#)) The most commonly involved lumbar joints are L4-5 and L5-S1. ([Dreyfus, 2003](#)) In the lumbar region, the majority of patients have involvement in no more than two levels. ([Manchikanti, 2004](#))

Mechanism of injury: The cause of this condition is largely unknown, but suggested etiologies have included microtrauma, degenerative changes, and inflammation of the synovial capsule. The overwhelming majority of cases are thought to be the result of repetitive strain and/or low-grade trauma accumulated over the course of a lifetime. Less frequently, acute trauma is thought to be the mechanism, resulting in tearing of the joint capsule or stretching beyond physiologic limits. Osteoarthritis of the facet joints is commonly found in association with degenerative joint disease. ([Cohen 2007](#))

Symptoms: There is no reliable pain referral pattern, but it is suggested that pain from upper facet joints tends to extend to the flank, hip and upper lateral thighs, while the lower joint mediated pain tends to penetrate deeper into the thigh (generally lateral and posterior). Infrequently, pain may radiate into the lateral leg or even more rarely into the foot. In the presence of osteophytes, synovial cysts or facet hypertrophy, radiculopathy may also be present. ([Cohen 2007](#)) In 1998, Revel et al. suggested that the presence of the following were helpful in identifying patients with this condition: (1) age > 65; (2) pain relieved when supine; (3) no increase in pain with coughing, hyperextension, forward flexion, rising from flexion or extension/rotation. ([Revel, 1998](#)) Recent research has corroborated that pain on extension and/or rotation (facet loading) is a predictor of poor results from neurotomy. ([Cohen2, 2007](#)) The condition has been described as both acute and chronic. ([Resnick, 2005](#))

Radiographic findings: There is no support in the literature for the routine use of imaging studies to diagnose lumbar facet mediated pain. Studies have been conflicting in regards to CT and/or MRI evidence of lumbar facet disease and response to diagnostic blocks or neurotomy. ([Cohen 2007](#)) Degenerative changes in facets identified by CT do not correlate with pain and are part of the natural degenerative process. ([Kalichman, 2008](#)) See also [Facet joint diagnostic blocks](#) (injections); & [Segmental rigidity](#) (diagnosis).

Suggested indicators of pain related to facet joint pathology (acknowledging the contradictory findings in current research):

- (1) Tenderness to palpation in the paravertebral areas (over the facet region);
- (2) A normal sensory examination;
- (3) Absence of radicular findings, although pain may radiate below the knee;
- (4) Normal straight leg raising exam.

Indictors 2-4 may be present if there is evidence of hypertrophy encroaching on the neural foramen.

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)**