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Notice of Independent Review Decision

August 4, 2015 Amended Decision Date: **August 17, 2015**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral L4-L5 and L5-S1 facet injection with fluoroscopy and monitored anesthesia

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

Pain Management Physician

REVIEW OUTCOME:

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

Overturned (Disagree)

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 patient is a male who was injured on xx/xx/xx. The patient developed low back pain after he pulled a 40-45 pound part out of the car and turned at the waist.

On August 28, 2014, performed a designated doctor evaluation (DDE) to determine the patient's extent of injury. opined that within reasonable medical probability the work-related incident did not cause L5-S1 protrusion mildly displacing the right S1 root and minimal protrusion at L3-L4 and L4-L5 with borderline spinal narrowing, but did cause aggravation of L5-S1 protrusion mildly displaces the right S1 root and minimal protrusion at L3-L4 and L4-L5 with borderline spinal narrowing of pre-existing conditions. I find that the compensable injury of 05/09/14 was a substantial factor in bringing about aggravation of these conditions, and without it, the aggravation and exacerbation of

pre-existing conditions would not have occurred. Specifically, the compensable injury does not include left renal cyst. The compensable injury extends to include the aggravation of L5-S1 protrusion mildly displaces the right S1 root and minimal protrusion at L3-L4 and L4-L5 with borderline spinal narrowing.

Review of records indicated the following:

“On May 12, 2014, diagnosed left lumbar sprain. Recommendations included physical therapy evaluation and treat on lumbar spine for essential functions, back education, functional improvement, and dynamic activities; Naprosyn; and injury precautions given.

From May 13, 2014, through June 9, 2014, physical therapy notes indicate the patient completed 10 sessions.

On May 22, 2014, and June 3, 2014, continued Robaxin and tramadol.”

On October 23, 2014, performed a DDE and diagnosed lumbar strain, L3-L4, L4-L5 and L5-S1 disc protrusion and pre-existing degenerative changes. While addressing the extent of injury, stated mechanism of injury, records and examination was consistent with a lumbosacral strain. Within reasonable medical probability, the L5-S1 disc protrusion is not compensable. Within reasonable medical probability, the L3-4 and L4-5 disc protrusions are not compensable. Within reasonable medical probability, the lumbar facet changes are not compensable.

Review of records indicated the following:

“On May 19, 2014, evaluated the patient for complaints of increasing pain. Straight leg raising was negative. X-rays are negative for acute changes. The impression was lumbar strain. The patient was to continue therapy and Robaxin.

On June 11, 2014, magnetic resonance imaging (MRI) of the lumbar spine indicated at L5-S1 an 8 mm shallow disc protrusion slight displacing the right S1 nerve root as it enters the right S1 lateral recess. At L4-5 there was a shallow protrusion largely in the epidural fat, facet degenerative changes were present, and borderline central canal narrowing. At the end of the report, the radiologist tells the L3-4 and L4-5 protrusions as minimal.

On June 19, 2014, said the patient is complaining of low back pain as well as left and right leg pain. The patient was on tramadol. On his review of the MRI, he said that the L4-5 disc protrusion produces bilateral lateral recess narrowing and at L5-S1, there was a central protrusion, which contacted the right S1 nerve root in the lateral recess. At L3-L4, there was a protrusion producing right over left foraminal encroachment. There was also foramina stenosis affecting the L3, L4, L5 nerve roots bilaterally. The patient had low back pain radiating to the left posterior thigh and the hip girdle. prescribed Lyrica and referred the patient to pain management. The patient was to be seen

back as necessary for any changes in his condition. On examination, there was full strength, except the right peroneal were 4+/5. Sensory and reflexes were intact.

On June 20, 2014, there was a peer review. His impression was lumbar strain. All other diagnoses in all medical probability were not produced or aggravated by the on-the-job injury.

On July 10, 2014, noted decreased sensation of the bilateral S1 dermatome; no atrophy or weakness. Knee jerks were 2 bilaterally. Ankle jerks are zero bilaterally. SLR was positive bilaterally. recommended an epidural steroid injection (ESI).

On July 15, 2014, has the patient on Flexeril and Tramadol.

On July 31, 2014, the patient was on Mobic, Skelaxin, and Ultracet.

On October 8, 2014, stated the patient was complaining of increased pain. Neurological was intact. Straight leg raising was negative.”

Magnetic resonance imaging (MRI) of the lumbar spine on May 18, 2015, showed moderate bulging disc at L3-L4 and posterior bulging lateralizing to the right at L5-S1; laminectomies were more extensive on the right at L5-S1. Mild posterior displacement of the right S1 nerve root sleeve in the subarticular lateral recess on the right at L5-S1. Prominent lumbar epidural fat causing attenuation of the thecal sac at and below the L2-L3 with relatively greater effacement of the CSF around the intrathecal nerve roots at L4-L5.

evaluated the patient on June 4, 2015, for bilateral lower lumbar pain, rated as 8-9/10. The patient reported increased back pain with ambulation, weakness in the limbs and insomnia. History was significant for a lumbar laminectomy at L5-S1 in January 2015. On examination, the patient appeared to be in mild distress. Straight leg raising (SLR) while seated was positive bilaterally for low back pain. Range of motion (ROM) was limited for extension by pain. The diagnosis was lumbar sprain/strain, lumbar facet arthropathy at L4-L5 and L5-S1 bilaterally and radiculopathy secondary to lumbar disc displacement. stated the patient had continued pain in the L5-S1 distribution and would need to see. if he would be a candidate for surgery. a lumbar facet injection was recommended at bilateral L4-L5 and L5-S1.

On June 11, 2015, stated the request for lumbar facet injection at the bilateral L4-L5 and L5-S1 with fluoroscopy and monitored anesthesia was not medically necessary. Rationale: *“Guidelines criteria have not been met. The patient is noted with complaints of pain in the lower back with weakness of the limbs, positive SLR, limited ROM with pain, diminished reflexes in the L4-L5 distribution and an antalgic gait. Typically, such injections in this clinical context have not been fully proven in medical literature to be an effective treatment. Therefore, this request is not medically reasonable and necessary at this time.”*

A utilization review on June 12, 2015, denied the request for lumbar facet injection at the bilateral

L4-L5 and L5-S1 with fluoroscopy and monitored anesthesia.

On July 6, 2015, the appeal for lumbar facet injection at the bilateral L4-L5 and L5-S1 with fluoroscopy and monitored anesthesia was denied.

According to medical necessity report completed on July 6, 2015, the request for the lumbar facet injection at the bilateral L4-L5 and L5-S1 with fluoroscopy and monitored anesthesia was not considered medically necessary. It was stated there were no red flags and/or significant positive objective orthopedic/neurologic findings, specifically complaints/signs of facet arthropathy or pain generators from facet joint to support the above request.

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

The requested procedure for bilateral L45 and L5S1 facet injections is approved. As per the ODG Guidelines, the criteria for bilateral 2 level facet injections have been met. Physical exam findings, 6/4/2015 as indicated above, included pain with extension, reduced ROM with pain, back pain (not leg pain) with a straight leg raise and no neurological deficit or radiculopathy. The patient has not had a fusion, has failed conservative care including 4 weeks of physical therapy, NSAIDS, and home exercise, and no more than 2 levels are to be performed.

REFERENCES:

As per ODG Guidelines, "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 = 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)]"

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES