

IRO NOTICE OF DECISION TEMPLATE – WC

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IRO REVIEWER REPORT

TEMPLATE -WC

DATE: November 11, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Thoracic Facet Blocks Rt T6-T7 T7-T8 64490 64491 77003 01992 J3301 J2250

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

The reviewer is certified by the American Board of Anesthesiology with over 6 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 male who was injured when he fell off a ladder onto his right side on XX/XX/XX.

04/21/15: MRI Right Shoulder report. IMPRESSION: Minimally displaced fracture extending through the base of the coracoid into the superior glenoid articular surface. Mild surrounding marrow edema and reactive soft tissue signal indicative of at least a subacute process. Intact rotator cuff. Signal extending deep to the anterior superior labrum adjacent to the fracture line. Underlying labral injury cannot be excluded. Mild synovial hypertrophy in the acromioclavicular joint.

04/23/15: The claimant was evaluated for low back pain and right leg pain. He complained of right-sided low back pain radiating into the right leg, particularly the lateral buttock and lateral thigh with associated numbness and tingling. He rated the pain as 7/10, constant, and aggravated with sitting and lying. Pain was relieved with standing and walking. On exam, he walked with a normal gait. Lumbar range of motion was slightly limited to 50 degrees of flexion and 30 degrees of extension. He had 5/5 strength in the bilateral lower extremities. He had slightly decreased sensation in the right leg in the L5 distribution and otherwise had intact sensation. He had 2+ DTRs. He had mildly positive right-sided SLR and negative left SLR. X-rays of the lumbar spine demonstrated no fracture or malalignment. DIAGNOSIS: Lumbar radiculopathy; lumbar strain. PLAN: MRI L spine; initiate physical therapy.

04/27/15: The claimant was evaluated for right shoulder pain that was getting better. He noted that therapy was helping and requested more. He was taking pain medicine. On exam, he had right shoulder tenderness if pushed firmly at the coracoid. He had a little bit of ptosis of the shoulders and held the shoulder in a scapula protracted position. There was no tenderness posteriorly or surround the body or medial border of the scapula. There was no tenderness at the acromion or along the clavicle. AROM was 88 degrees forward flexion T12, internal rotation 38 degrees, extension rotation 97 degrees. He could tolerate Neer, Jobe, and Hawkins tests without much pain up to about 90 degrees. Neurovascular status was intact. Elbow, wrist, and fingers were normal. ASSESSMENT: Right shoulder coracoid base fracture, minimally displaced, 7-week old injury. He really has not improved his motion since I last saw him, but he feels like he is improving in therapy. He is seeing Dr. for lumbar spine and awaits an MRI. PLAN: Continue gradual range of motion in therapy. 8 more visits of physical therapy. Surgery not recommended, as he was improving. He did not need medication refills.

04/30/15: Therapy note indicated that his current medications were ibuprofen 600 mg t.i.d. p.r.n., tramadol 50 mg 1-2 q. 4-6 hrs p.r.n., gabapentin 100 mg, and Norco 5/325 mg. He participated in visit 7 of 14.

05/06/15: MRI lumbar spine report. IMPRESSION: Differential consideration for the appearance of the T12 vertebral body include sequela from remote, comminuted compression fracture deformity with 4 mm retropulsion and (illegible) fibrous union versus a congenital butterfly (illegible) vertebra. There is no evidence of mass effect upon the conus or disc herniation at T11-T12 or T12-L1. Rightward convexity of the thoracolumbar (illegible) curvature has (illegible) apex at this level. Clinical and plain film correlation is advised. Consider CT of the lower thoracic spine without intravenous contrast. Mild anterior wedge deformity of the T11 vertebral body without altered T1 or T2 marrow signal to indicate an acute or subacute compression injury. No lumbar vertebral body compression fracture deformity or spondylolisthesis. Annular bulge at L3-L4 and L4-L5 without disc herniation, central canal stenosis, or exiting nerve root compression. No disc herniation, central canal stenosis, or exiting nerve root compression involving the remaining lumbar intervertebral disc levels. There is no evidence of abnormal intradural enhancement.

05/14/15: The claimant was evaluated for a T11 compression fracture. It was noted that he had been placed in a TLSO following his 03/02/15 injury. He noted that his pain had improved significantly. He rated it as 5/10. On exam, he was neurologically intact in the bilateral lower extremities to motor, sensory, and reflex function. MRI was reviewed demonstrating small concentric disc bulges at L3-L4 and L4-L5 and a known T11 compression fracture with 30% vertebral body height loss. PLAN: His compression fracture is healing. His back pain is improving. I recommend some physical therapy for approximately 4-6 weeks. At that point, he can likely return to work. This does not need surgical intervention. He is discharged from my care. He can follow up with the referring doctor after a course of physical therapy.

07/21/15: The claimant was evaluated. It was noted that he still had back pain at T11-T12 rated 5/10 and worse with lifting. He had no urinary or bowel problems. It was noted that physical therapy had not been started. On exam, he had tenderness at the T10 through T12 area. No muscle spasms. Full range of motion. Sensation intact. PLAN: physical therapy, light duty.

07/22/15: MRI cervical spine report. IMPRESSION: C6-C7 disc protrusion (herniation) indents the thecal sac. Neural foramina and canal are patent.

08/24/15: The claimant underwent physical therapy for this thoracic and lumbar spine. He was also taught a home exercise program. He was discharged from therapy services secondary to the anticipated goals or expected outcomes for the patient having been achieved. He was instructed to continue with independent HEP and follow up with physician on 09/01/15.

08/27/15: The claimant was evaluated for upper back pain rated 7 to 9/10 with shooting pain down right leg to foot with occasional numbness. It was noted that physical therapy was "minimal or no help." On exam, DTRs were intact. SLR negative bilaterally. No sensory changes noted. Facet tenderness at T7-T8 and T6-T7 on the right. Thoracic pain on rotation. DIAGNOSIS: Thoracic strain. PLAN: Thoracic facet block T6-T7, T7-T8 right. It was noted that he had a

degree of anxiety about needles. He expressed a mental and/or a psychological impediment to not having a degree of relaxation medication whilst this procedure with needles is being performed. "Per American Society of Anesthesiologists Guidelines is a candidate for MAC."

09/02/15: UR. RATIONALE: The patient has axial thoracic pain and localized tenderness. The MRI and conservative therapy have failed. Thoracic MBB are technically easier than intra-articular injection. However, as there is currently a lack of supporting evidence published in peer-reviewed literature, the request is not recommended.

09/10/15: The claimant was evaluated. Exam was unchanged since previous visit. The plan remained the same – thoracic facet block T6-T7, T7-T8, right; if successful, RFA with PT.

10/07/15: UR. RATIONALE: The guidelines state the clinical presentation should be consistent with facet joint pain, signs and symptoms and one set of diagnostic medial branch blocks is required with a response of equal to or greater than 70 percent. Facet blocks are limited to pain that is nonradicular, and there should be failure of at least 4 to 6 weeks of conservative therapy. There is no documentation that the claimant has had failure of conservative therapy; the physical therapy notes stated the claimant had met goals and discharged. There is no imaging provided for review to indicate any type of facet pathology at the requested levels.

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

The previous adverse decisions are upheld. The claimant has axial thoracic pain and localized tenderness. The MRI and conservative therapy have failed. However, for thoracic MBB, there is currently a lack of supporting evidence published in peer-reviewed literature. ODG criteria have not been met. Therefore, the request for Thoracic Facet Blocks Rt T6-T7 T7-T8 64490 64491 77003 01992 J3301 J2250 is not certified.

ODG:

<p>Facet joint medial branch blocks (therapeutic injections)</p>	<p>Not recommended except as a diagnostic tool. Minimal evidence for treatment.</p> <p><i>Pain Physician 2005:</i> In 2005 <i>Pain Physician</i> 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 <i>Pain Physician</i>.] The average relief per procedure was 11.9 ± 3.7 weeks.</p> <p><i>Pain Physician 2007:</i> 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). The AHRQ comparative effectiveness study on injection therapies for LBP concluded that facet joint corticosteroid injections are not effective for presumed facet joint pain. (Chou, 2015) See also Facet joint intra-articular injections (therapeutic blocks).</p>
<p>Facet joint diagnostic blocks (injections)</p>	<p>Criteria for the use of diagnostic blocks for facet “mediated” pain:</p> <p>Clinical presentation should be consistent with facet joint pain, signs & symptoms.</p> <ol style="list-style-type: none"> 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

	<p>patient should also keep medication use and activity logs to support subjective reports of better pain control.</p> <p>10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)</p> <p>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)]</p>
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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)