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Notice of Independent Review Decision

02/04/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 1 lumbosacral medial branch block at the bilateral L3-L4 and L4-L5 between 12/11/2014 and 2/9/2015

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

Board Certified PM&R; Board Certified Pain Medicine

REVIEW OUTCOME:

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

X 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 patient is a female whose date of injury is xx/xx/xx. The patient reported low back pain after a ground-level fall to the floor. The patient was seen and diagnosed with lumbar sprain and strain and lumbago/low back pain. MRI of the lumbar spine dated 08/05/13 reportedly showed multilevel lumbar spondylosis which is most significant at L4-5 where there is degenerative disc change and facet arthropathy causing moderate to severe right foraminal narrowing and severe left foraminal narrowing. Note dated 11/11/13 indicates that she has been to 4 sessions of physical therapy and is doing a home exercise program. The patient subsequently underwent bilateral L4 transforaminal epidural steroid injection on 12/13/13 and reported 50% improvement in her pain on follow up note dated 12/27/13. She underwent bilateral L5 transforaminal epidural steroid injection on 06/13/14 and reported approximately 50% improvement in her pain on 06/27/14. Office visit note dated 10/29/14 indicates that she has completed 8 sessions of physical therapy. The patient underwent bilateral L4-5 and L5-S1 facet injections on 11/21/14. Office visit note dated 12/09/14 indicates that she

notes greater than 50% improvement in her pain.

Initial request for 1 lumbosacral medial branch block at the bilateral L3-4 and L4-5 between 12/11/2014 and 02/09/2015 was non-certified on 12/16/14 noting that the patient has already undergone bilateral L4-5 and L5-S1 facet joint injections. The rationale for the request for an additional set of bilateral injections at the L4-5 is unclear and would not be supported. In addition, a physical examination was not documented to show that the patient had the presence of facet joint pain signs and symptoms to indicate the need for medial branch blocks. Furthermore, there was no documentation showing that the patient had undergone any conservative treatment with physical therapy following the previous injections. The denial was upheld on appeal dated 01/02/15 noting that the previous issues had not been addressed.

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

Based on the clinical information provided, the request for 1 lumbosacral medial branch block at the bilateral L3-4 and L4-5 between 12/11/2014 and 02/09/2015 is not recommended as medically necessary, and the two previous denials are upheld. The submitted records fail to provide a current, detailed physical examination to establish the presence of facet-mediated pain as required by the Official Disability Guidelines. The patient underwent prior facet injections at L4-5 and L5-S1. The Official Disability Guidelines note that one set of medial branch blocks are supported, and a second confirmatory set of blocks is not recommended. Given the current clinical data, the requested lumbosacral medial branch blocks are not supported as medically necessary in accordance with the Official Disability Guidelines.

IRO REVIEWER REPORT TEMPLATE -WC

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Low Back Chapter

Facet joint diagnostic blocks (injections)

Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered “under study”). Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. (Cohen, 2007) (Bogduk, 2000) (Cohen2, 2007) (Manchukonda, 2007) (Dreyfuss, 2000) (Manchikanti2, 2003) (Datta, 2009)

Etiology of false positive blocks: Placebo response (18-32%), use of sedation, liberal use of local anesthetic, and spread of injectate to other pain generators. The concomitant use of sedative during the block can also interfere with an accurate diagnosis. (Cohen, 2007) The use of sedation during diagnostic injections may increase the rate of false-positive blocks and lead to misdiagnoses and unnecessary procedures, but has no effect on satisfaction or outcomes at 1-month. (Cohen, 2014)

MBB procedure: The technique for medial branch blocks in the lumbar region requires a block of 2 medial branch nerves (MBN). The recommendation is the following: (1) L1-L2 (T12 and L1 MBN); (2) L2-L3 (L1 and L2 MBN); (3) L3-L4 (L2 and L3 MBN); (4) L4-L5 (L3 and L4 MBN); (5) L5-S1: the L4 and L5 MBN are blocked, and it is recommended that S1 nerve be blocked at the superior articular process. Blocking two joints such as L3-4 and L4-5 will require blocks of three nerves (L2, L3 and L4). Blocking L4-5 and L5-S1 will require blocks of L3, L4, L5 with the option of blocking S1. (Clemans, 2005) The volume of injectate for diagnostic medial branch blocks must be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate), as increased volume may anesthetize other potential areas of pain generation and confound the ability of the

block to accurately diagnose facet pathology. Specifically, the concern is that the lateral and intermediate branches will be blocked; nerves that innervate the paraspinal muscles and fascia, ligaments, sacroiliac joints and skin. (Cohen, 2007) Intraarticular blocks also have limitations due to the fact that they can be technically challenging, and if the joint capsule ruptures, injectate may diffuse to the epidural space, intervertebral foramen, ligamentum flavum and paraspinal musculature. (Cohen, 2007) (Washington, 2005) (Manchikanti, 2003) (Dreyfuss, 2003) (BlueCross BlueShield, 2004) (Pneumatics, 2006) (Boswell, 2007) (Boswell2, 2007) A recent meta-analysis concluded that there is insufficient evidence to evaluate validity or utility of diagnostic selective nerve root block, intra-articular facet joint block, medial branch block, or sacroiliac joint block as diagnostic procedures for low back pain with or without radiculopathy. (Chou2, 2009) This study suggests that proceeding to radiofrequency denervation without a diagnostic block is the most cost-effective treatment paradigm, but does not result in the best pain outcomes. (Cohen, 2010) See also Facet joint pain, signs & symptoms; Facet joint radiofrequency neurotomy; Facet joint medial branch blocks (therapeutic injections); & Facet joint intra-articular injections (therapeutic blocks). Also see Neck Chapter and Pain Chapter.

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)]