

MEDRx

3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069
Ph 972-825-7231 Fax 972-274-9022

Notice of Independent Review Decision

DATE OF REVIEW: 1/16/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a medial branch block at lumbar right L5 level and sacral Ala under Fluoroscopy and sedation as an outpatient.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation.

REVIEW OUTCOME

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

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a medial branch block at lumbar right L5 level and sacral Ala under Fluoroscopy and sedation as an outpatient.

A copy of the ODG was not provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The Injured Worker sustained a work related injury on xx/xx/xx, when he was on one knee, and did a sudden turn, and felt pain in the mid back and lower back. He was evaluated and treated who diagnosed 926.11 crushing injury of back and 847.20 lumbar sprain. X-rays

were reported to be negative for fracture or dislocation. Lower extremity exam showed vascular intact, normal deep tendon reflexes, normal sensation, normal muscle strength, negative right and left straight leg raising. Treatment included physical therapy, ice and medications. On October 7, 2014 noted decreased muscle spasm along the paraspinal muscles. Tenderness had decreased. Lower extremity vascular status was intact. Deep tendon reflexes were normal. Sensation was normal. Muscle strength was normal. Straight leg raising was negative bilaterally. MRI of the lumbar spine was reported to show mild loss of disc space at L5-S1 with disc bulging centrally at L5-S1 without central or foraminal stenosis. There was mild diffuse disc bulge at L4-L5 and it L2-L3. recommended orthopedic referral for evaluation of left gluteal pain and for possible left sacroiliac injection. Physical therapy was continued.

saw the injured worker October 14, 2014 for orthopedic consultation. Examination revealed left SI joint tenderness to palpation with moderate restriction of lumbar motion. Fabere and Gaenslen's tests were positive on the left and negative on the right. Deep tendon reflexes were normal. diagnosed lumbar sprain 847.2 and sacroiliac pain 720.2. He recommended injection of the left sacroiliac joint with Marcaine and Celestone when authorized. On 10/21/2014 saw the worker for left SI injection. A home therapy stretching program was discussed. Activities to avoid were discussed.

At the request the worker was seen. 11/20/2014 for pain management evaluation and for treatment of back pain and left leg pain. Pain persisted despite physical therapy and medications, but range of motion had improved in response to physical therapy. On examination there was mildly reduced lumbosacral range of motion with pain during range of motion and with facet loading. Left straight leg raising was positive. FABER and Genslen tests were negative. Waddell signs were not present. Gait was normal. recommended lumbosacral medial branch block, followed by three sessions of physical therapy. He recommended back education.

On November 11, 2014 the worker reported that the recent left SI injection was not very helpful. There was left paraspinal muscle tenderness to palpation with moderately limited lumbar range of motion. Straight leg raising was positive to the left proximal calf. He had a left antalgic gait. The diagnosis was lumbar sprain 847.2, sacroiliitis 720.2 and lumbar radiculopathy 722.10. recommended epidural steroid injection, single level. noted that the examination was somewhat atypical for radiculopathy but he does have protrusion bilaterally at L5-S1 and that ESI may prove helpful. He recommended follow-up in 3 to 4 weeks.

The proposed procedures were non-authorized. On 12/15/2014, a request was submitted for reconsideration for proposed bilateral L5 and sacral block with fluoroscopy and sedation. On December 18, 2014 the proposed procedures were non-certified after reconsideration.

The injured worker for follow up December 18, 2014. The worker reported that pain was the same as at the previous visit, radiating into the left leg and buttocks with an electrical sensation, worse in cold weather. On the review of systems he reported joint pain, back pain, muscle pain, limitation of motion. On examination, touch sensation was intact. Lumbosacral range of motion was mildly reduced with mild pain on range of motion. Facet loading caused

pain. Rotation of the back to the left caused pain in the lower back. Straight leg raising was negative bilaterally. Femoral nerve stretch test was negative bilaterally. Fabere and Gaenslen tests were negative. Waddell signs were not present. He had an antalgic gait. The diagnosis was lumbago and lumbar HNP without myelopathy.

DIAGNOSTIC STUDIES

2014/09/22 MRI of the lumbar spine without contrast, M.D.

- There is mild loss of disc space height and signal at L5-S1 and to a lesser extent at L4-L5 and L1-L2.
- There is disc bulging centrally with extension to both sides of the midline at L5-S1. This is contained by the ventral epidural fat. The AP extent is 2-3 millimeters.
- There is subtle annular fissuring. There is no central or foraminal stenosis.
- There is also a mild diffuse disc bulging at L4-L5 and at L2-L3 with a more focal left paracentral disc bulge at L1-L2.
- There is no nerve root compression or displacement at any of these levels. There is no significant central or foraminal stenosis at any of these levels. The conus is unremarkable.

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

According to the findings on physical examination on December 18, 2014 the clinical presentation was consistent with facet joint pain and therefore meets the criteria for diagnostic medial branch blocks.

However, the request for sacral ala injection cannot be recommended. According to the ODG –TWC Integrated Treatment/Disability Duration Guidelines, Hip & Pelvis (Acute & Chronic) (updated 10/09/14), Criteria for the use of sacroiliac blocks:

8. The block is not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block.

Therefore, the requested procedures, as worded on the December 18, 2014 Surgery Pre-Authorization Form, cannot be authorized. Please note that although the CPT code for sacral injection was not submitted with the request, the worded request takes precedence over the listed CPT codes.

Suggested indicators of pain related to facet joint pathology, listed in the ODG Guidelines:

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.

According to the ODG –TWC ODG Treatment Integrated Treatment/Disability Duration Guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 11/21/14), pertaining to facet joint diagnostic blocks (injections)

Criteria for the use of diagnostic blocks for facet “mediated” pain: (Clinical presentation should be consistent with facet joint pain, signs & symptoms as described in the ODG Guidelines)

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)]

According to the ODG –TWC Integrated Treatment/Disability Duration Guidelines, Hip & Pelvis (Acute & Chronic) (updated 10/09/14), pertaining to Sacroiliac joint blocks, Criteria for the use of sacroiliac blocks:

8. The block is not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block.

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)