AccuReview

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

B/L L4-5, L5-S1 MBB

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

This physician is Board certified in Anesthesiology 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]:

11-11-13: New Patient Encounter: lower back pain radiating to bilateral legs, constant 8/10 pain. Triggers: at rest, while working, when standing, while walking, with exercise, with any activity. Modifying Factors: Improves – stopping activity, with lying down, with pain medication, when position changed, with rest; Worsens – at night, while walking, with activity, with exercise, with ROM, while sitting, with standing. Associated S/S: fatigue, stiffness, nerve pain. Previous Therapies: blocks-pain relief was minimal, TENS unit. Current Medications: Amitriptyline, Gabapentin, naproxen, tizanidine. ROS: Musculoskeletal: back-complains of limitation of activity, limitation of movement, pain with cause, stiffness. Joints-complains of aching, limitation of joint movement, morning stiffness. Muscles-complains of aches, cramps with exertion, limitation of activity, limitation of movement, weakness. Psychiatric-complains of depression. PE: Musculoskeletal: Back: lumbar spine: scar-yes, ROM-decreased ROM; strength and tone – diminished strength and tone due to pain; Inspection – muscle spasms – at Bilateral piriformis; stiffness, SCS Implant Medtronics. Problems: Sprain/Strain – Back 847.9. New Medications: Morphine 30mg PO BID. Plan: claimant agreed to adhere to contract for treatment of opioids, UDS today, she has had surgery and still sees him regularly, return in one month.

06-12-14: Established Patient Encounter: lower back pain radiating down bilateral LE's, pain 5/10. PE: unchanged. Problems: Sprain/Strain – Back 847.9. New Medication: Morphine 30mg. Plan: Claimant complained of increased lower back pain, will request for Lumbar MBB at L4-L5, L5-S1. She is tender today over the facets and pain with flexion and extension. Claimant currently stable on current medication, refills were given today. Return to clinic after injections therapy is completed.

08-07-14: Established Patient Encounter. Claimant returned to clinic today for follow up on lower back pain radiating to bilateral lower extremities. Injection therapy was denied by Insurance. At this time recommend appeal, as L4-L5,

L5-S1 MBB will benefit this claimant. Medication refills given.

09-04-14: Established Patient Encounter: lower back pain radiating down bilateral LE's. Current medications: Amitriptyline, Gralise, naproxen, tizanidine. PE: Musculoskeletal: Back: lumbar spine: scar-yes, ROM-decreased ROM; strength and tone – diminished strength and tone due to pain; Inspection – muscle spasms – at Bilateral piriformis; stiffness, SCS Implant Medtronics. Tenderness – at bilateral facet joint levels from: - through L- 4 levels, through S1. Problems: sprain/strain – Back 847.9. New medications: morphine 30mg. Plan Note: Refill Morphine ER 30mg BID, refill Morphine IR 30mg, refill Amitriptyline 25mg QID, refill Gralise 600mg (3) QHS, refill Zanaflex 4mg TID, refill naproxen 500mg BID, will resubmit for approval for a bilateral L4-5, L5-S1 MBB, RTC in one month for medication evaluation, UDS done in office today for compliance issues.

10-02-14: Established Patient Encounter: lower back pain radiating down bilateral LE's. PE: unchanged. Problems: sprain/strain back 847.9. Plan Note: refill medications, will resubmit for approval for a bilateral L4-5, L5-S1 MBB, RTC in 2 month for medication evaluation. The claimant is having radicular type pain unresponsive to conventional noninvasive treatments such as PT, rehabilitation and the use of medication for more than four weeks. At this point would recommend proceeding with this minimally invasive treatment in order to reduce her pain level. This is the simplest and least invasive procedure for discogenic and radicular derived pain. It is based on the research that chemical and mechanical inflammation of nerve roots results in most lumbar and lower extremity pain. These corticosteroid injections are targeted towards these nerve roots, in order to counter the inflammation and relieve the pain. The levels have been selected after careful evaluation of the claimant's diagnostic studies as well as detailed physical examination. The goal of treatment is to minimize the effects of the claimant's injury, prevent further disease, maintain or enhance the claimant's functional level, allow her to perform appropriate rehabilitation; decrease the amount of medication she is on and promote safe return to normal activities as soon as possible.

03-09-15: Established Pain Encounter: lower back pain radiating down bilateral LE's, pain 7/10. PE: Musculoskeletal: gait and station: antalgic, limping. Back: lumbar spine: tenderness at bilateral facet joint levels from L3 through S1. Problems: sprain/strain back 847.9. New Medications: ACP 500, Morphine 30mg, MS Contin 60mg. Plan Note: refill medications, still pending IRO for a bilateral L4-5, L5-S1 MBB, will return Wednesday for a reprogramming with Medtronics, RTC in 1 month for medication evaluation.

06-01-15: UR. Reason for denial: Non-certify medial branch blocks bilateral L4-5 and L5-S1 since is lack of clinical information. There is a question with regards to ruling out other pain generators particularly radiculopathy given history of radiating pain from the low back down to the bilateral lower extremities. There is no documentation of a recent neurologic examination or provocative nerve root testing to assess for lumbar/lower extremity radiculopathy. There is also notation of a "stimulator" and therefore question with regards to whether a spinal cord stimulator is in place and functioning with respect to neuropathic/radicular pain control. Notation of a history of "back surgery" but there is no notation with regards to the type of surgery particularly if the fusion was involved at the levels to be blocks. There is question with regards to any recent diagnostic studies, including MRI imaging and/or electrodiagnostic studies, to clarify pain generators. History of previous treatment noted including "blocks with minimal pain relief." There is question as to clarification of these previous "blocks" particularly if the same as the ones currently requested. Additionally there is question with regards to more recent conservative measures including physical therapy, home exercise program, and activity modification prior to progressing to more invasive procedures.

07-01-15: UR. Reason for denial: Within the associated medical file, there is documentation of low back pain, failure of conservative treatment (NSAIDs), and no more than 2 joints level to be injected in one session. However, given documentation of subjective (low back pain that radiates down bilateral lower extremities) findings, there is no documentation of pain that is non-radicular. In addition, there is no documentation of failure of additional conservative treatment (home exercise and PT) prior to procedure for at least 4-6 weeks. Furthermore, given documentation of a previous unspecified back surgery, there is no (clear) documentation of no previous fusion procedure at the planned injection level. Moreover, given documentation of treatment with prior blocks, there is no (clear) documentation if this is a request for an initial or additional medial branch block. Lastly, there is no documentation of a Discussion/Rationale as to why such may not be applicable. Therefore, certification of the requested Appeal B/L L4-5, L5-S1 MBB is not recommended.

07-02-15: Established Patient Encounter: lower back pain radiating down bilateral LE's, pain 9/10. PE: unchanged. Problems: sprain/strain back 847.9. Plan Note: refilled medications, bilateral L4-5, L5-S1 MBB in approval stages with WC carrier, no updates, will contact a Medtronic rep for a reprogramming session for claimant, RTC in 1 month for medication evaluation.

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

Previous adverse determinations are upheld and agreed upon. Based on the records provided, there is no documentation that the pain is non-radicular. Additionally, there is no documentation of failure of conservative treatment prior to the procedure for at least 4-6 weeks. Furthermore, given documentation of a previous unspecified back surgery, there is no (clear) documentation of previous fusion procedure at the planned injection level. Per ODG, both failure of conservative therapy and nature of pain must be documented. Therefore, after reviewing the medical records and documentation provided, the request for B/L L4-5, L5-S1 MBB is non-certified.

Per ODG:

Facet joint medial branch blocks (therapeutic injections)	Not recommended except as a diagnostic tool. Minimal evidence for treatment. *Pain Physician 2005:* In 2005 *Pain Physician* 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 that 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 *Pain Physician.*] The average relief per procedure was 11.9 ± 3.7 weeks. *Pain Physician 2007:* 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).

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)**