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**May 5, 2016**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Denial of medial branch nerve block at L3, L4, L5 and S1 nerve roots, fluoroscopy, sedation

**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:

X Partially Overturned (Agree in part/Disagree in part)

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 was working as a controls programmer within the applications department of XX of XX when the accident occurred. He reported while going down the staircase, the door started to close on its own and it hit him on his back of the head knocking him forward down the staircase. The door did not budge once it closed, so all of the inertia was placed on his lower back. He pushed from underneath as much he could. He felt extreme pain in the head and in the lower back. He ended up with a knot on the back of his head. He continued working for the rest of the day, but he could barely walk from the car to his room in the evening. Subsequently, the headache was better but the lower back pain had gotten worse. He reported major back surgery for a ruptured disc in XX/XXXX.

On XX/XX/XX, the patient was seen for a follow-up. The patient had a history of ongoing lumbar spine pain that had required an epidural steroid injection (ESI) approximately once every six months to one year. The injections offered him 60%+ pain relief. Overall, the patient was working full time, but was having a recurrence of severe pains. He reported the pains did intensify while at work. He

described the pain as a constant aching in the lumbar back that had become sharp in nature. The pain radiated into the buttocks occasionally. Examination revealed some limited back flexion due to moderate lumbar spine pain. Straight leg raising bilaterally to about 35 degree did produce some pain in the lumbar back with some discomfort radiating down the left leg. There were trigger point areas over the lumbar paraspinal and gluteal muscles. The diagnoses were lumbar discogenic pain, degenerative disc disease (DDD), pain with re-exacerbation of the spine pains, myofascial pain syndrome compounded by trigger point areas. XX recommended a transforaminal ESI at the L4 level bilaterally along with trigger point injections (TPI) at two or three sites. Darvocet N was continued. He was recommended to continue back to full-duty status.

On XX/XX/XX, the patient underwent bilateral transforaminal lumbar ESIs at L4, TPI x2, under fluoroscopic guidance and epidurography with interpretation.

On XX/XX/XX, the patient was evaluated for severe lumbar back pain. Apparently, he had an exacerbation of pain over the past two days, which was not responsive to bedrest and analgesics. He was frustrated with the ongoing discomfort. The pains were limiting him from what he was able to do. He requested injections as that was the only treatment that had helped him with the pains long term. Examination showed a well-healed scar on the lumbar spine. Range of motion (ROM) of the back in flexion and extension was somewhat limited because of mild to moderate lumbar spine pain. Straight leg raising (SLR) bilaterally to about 35 degrees produced moderate pain in the lumbar region and some mild discomfort that went into his buttocks and slightly into his posterior thighs. Magnetic resonance imaging (MRI) of the lumbar spine dated XX/XX/XX, revealed a disc herniation at L4-L5, which was more central and put pressure onto the thecal sac. At L5-S1, there was a small disc protrusion that barely touched the thecal sac. There was surgery in the lamina on the left side. XX assessed lumbar discogenic pain, lumbar disc displacement, re-exacerbation of severe lumbar spine pain and myofascial pain syndrome compounded with trigger point areas. XX recommended a transforaminal ESI at L4 bilaterally and TPI of painful muscles.

On XX/XX/XX, the patient was seen in follow-up for recurrence of severe lumbar back pain. Sometimes, the patient felt cramping pains going into the left thigh and leg. The recommended transforaminal ESI were denied by insurance carrier on two occasions. The patient was encouraged if his pain persisted he needed to argue that with his case adjustor. Trigger point injections of the lumbar paraspinal muscles were performed at L4 on the left and L5 on the right.

On XX/XX/XX, XX/XX/XX, and XX/XX/XX, the patient was evaluated for follow-up visits. The patient reported low back pain radiating down to the right lower extremity and involving the anterior thigh with numbness to the left leg. He rated the pain at 3/10. The diagnoses were low back pain, displacement of lumbar intervertebral disc, and lumbar radiculopathy. The patient was advised to continue pain medications. On XX/XX/XX, XX prescribed a Medrol Dosepak, Flector patches, gave samples of Amrix, and refilled Norco. Lumbar MRI was ordered.

On XX/XX/XX, the patient was evaluated for evaluation of his low back pain. Pain scale was 4/10. The patient reported no change in his pain. The MRI had been denied. His blood pressure (BP)

was 160/108 mmHg and BMI was 30.52. He reported the Medrol Dosepak had helped. Skelaxin was prescribed and Norco was refilled. He was advised to stop Amrix samples and follow-up with his primary care physician (PCP) regarding blood pressure.

On XX/XX/XX, and XX/XX/XX, the patient was evaluated in follow-up for low back pain. The patient was encouraged to participate in a home exercise regimen and conservative management. On XX/XX/XX, XX advised the patient to continue the home exercise program (HEP) and continue to use less medication with less pain and to avoid driving while on medications. He was stable on his medication regimen, which allowed him to participate in his activities of daily living (ADLs).

On XX/XX/XX, and XX/XX/XX, the patient was seen for follow-up of low back pain. He reported he developed pain six weeks ago that was stemming from his back to the right leg. Norco was continued. He underwent urine toxicology. He was advised to continue with his treatment plan and home stretching and exercises. He was advised to follow up with his primary care physician (PCP) for general healthcare maintenance.

On XX/XX/XX, and XX/XX/XX, the patient was seen in six monthly follow-up for low back pain. XX recommended continuing conservative care. The patient was able to participate in his daily activities and work with the prescribed medication regimen.

On XX/XX/XX, XX/XX/XX, XX/XX/XX, and XX/XX/XX, the patient was seen for follow-up visits XX for continued low back pain. He rated the pain at 4-6/10. He reported he got numbness to the left thigh a few seconds to a minute after lying down. The patient was advised to continue Norco, continue to work full time and continue stretching exercises. On XX/XX/XX, the patient reported severe low back pain of 10/10. He stated he bent down to put on his sock and the pain recurred in the right lower lumbar region. XX felt the pain was due to dysfunctional facet joints. XX recommended intraarticular steroid injection at the right L4-L5 and L5-S1 under fluoroscopic guidance. He increased Norco dosage and refilled it. On XX/XX/XX, XX performed intraarticular steroid injection on the right L4-L5 and L5-S1 level. On XX/XX/XX, the patient reported 50% relief status post lumbar facet joint injections. XX recommended radiofrequency thermal ablation (RFTA) for long term relief.

On XX/XX/XX, the patient was seen in follow up for low back pain. He reported the pain had been coming and going and had become more intense. He was frustrated with the increasing pain. XX recommended obtaining a new lumbar MRI.

On XX/XX/XX, the patient underwent MRI of the lumbar spine at XX, which revealed broad-based disc herniation at L4-L5 and L5-S1 with compression of L4, L5 and S1 nerve roots, broad-based annular disc bulge with annular tearing at L3-L4 and impression on both L3 nerve roots by intraforaminal disc, broad-based annular disc bulge with annular tearing at L2-L3 and abutment of the right L2 nerve root in the neural foramen and right paracentral disc herniation at L1-L2 with abutment of the right L2 nerve root in the lateral recess.

On XX/XX/XX, the patient reported a pain score of 5/10 and noted the low back pain was deep to his spine. He was able to work and do his ADLs but it was getting difficult to do so due to the pain. He was not able to lift any weights. He felt his pain shifted from side to side. He was using the transcutaneous electrical nerve stimulation (TENS) unit and needed a prescription for the pads. XX reviewed his MRI and indicated multiple disc herniations that were likely contributing to the pain. XX recommended a lumbar epidural steroid injection (ESI) at L5-S1 and continued Norco.

On XX/XX/XX, and XX/XX/XX, XX saw the patient in follow-up. The patient was wondering how his ESI had been denied. He was hoping to get the ESI for pain relief as his pain was still very limiting to him. Plan was to schedule lumbar ESI at L5-S1 level for pain relief. Norco was refilled. On XX/XX/XX, the patient reported a pain of 9/10. He stated the Norco helped him tolerate his pain. The patient was dealing with a family loss and wanted to hold off on injections. He desired to proceed with conservative care.

On XX/XX/XX, the patient was evaluated by XX. He reported a pain of 7/10, constant, throughout the day and worse with activity. Lumbar ESI was planned at the L5-S1 level. Neurontin was prescribed.

On XX/XX/XX, XX adverse determination Notice, XX denied the request for translaminar ESI lumbar L5-S1. Rationale: *“Based on the extremely chronic nature of the condition and the lack of detailed discussion of the prior surgery results and post-op treatment and lack of discussion of prior injections over the years, and lack of new hard clinical indications for need for invasive ESI, at this time, according to ODG (low back) Treatment Guidelines, the request was not medically necessary.”*

On XX/XX/XX, and XX/XX/XX, the patient reported continued low back pain of 7/10. He stated the pain was constant throughout the day and felt he had been hurting more due to the long hours he had been putting in at work. He wanted to proceed with conservative management. XX had received the denial for ESI recommendation. He recommended continuing Norco and Neurontin and opined the patient could require a surgical consultation in the future.

On XX/XX/XX, the patient reported increase in low back pain. He was working and bent forward and then up and felt severe pain in the low back and the legs. He was unable to straighten up fully and walked with a limp. XX assessed a severe exacerbation of low back and lower extremity pain. He reviewed a lumbar MRI from XX, which showed some disc pathology at the lower disc levels and recommended a new lumbar MRI. He increased Norco and prescribed Zanaflex and Toradol. The patient was given a Depo-Medrol injection. XX would decide on further treatment plan once MRI results were reviewed. The patient was referred to a spine surgeon.

On XX/XX/XX, the patient underwent MRI of the lumbar spine at XX. The study revealed multilevel degenerative changes. Postsurgical changes of left-sided laminotomy were present at L3-L4, L4-L5, and L5-S1. There was no significant canal stenosis at any level. There was a central disc extrusion with inferior migration at L3-L4. There was moderate-to-severe bilateral neural foraminal narrowing at L4-L5 and L5-S1 with facet degenerative change encroaching on the exiting nerve

roots and mild-to-moderate neural foraminal narrowing at L3-L4. Multilevel facet degeneration was noted; severe disc degeneration at L4-L5. There was mild-to-moderate disc degeneration at other levels. Findings included diffuse disc bulge at L1-L2 measuring 2-3 mm posteriorly, mild facet degeneration, and mild bilateral neural foraminal narrowing. At L2-L3, diffuse disc bulge measuring 2.3 mm posteriorly in addition to mild osteophyte formation with mild facet degeneration and mild right and minimal left neural foraminal narrowing.

On XX/XX/XX, XX noted the patient was not a candidate for surgical intervention and recommended conservative management. The patient underwent a urine drug screen (UDS). He was able to decrease the amount of hydrocodone that was given to him during his initial exacerbation of pain. He was advised to continue with the current pain medication regimen as it was beneficial to his residual low back pain.

On XX/XX/XX, and XX/XX/XX, the patient reported having increased exacerbation of his low back pain while doing his everyday activities. XX gave him Toradol and Depo-Medrol injection and recommended proceeding with diagnostic medial branch blocks to the painful facets at the L3, L4, L5, and S1 levels bilaterally. He stated that if the patient obtained 50% relief or more for the duration of the local anesthetic, then he would be a good candidate for RFTA to those nerves innervating the facet joints.

On XX/XX/XX, in a letter of medical necessity, XX documented the patient developed an on-the job injury with subsequent severe low back pain. Physical therapy in the past had not been effective. The patient had had continued severe pain in spite of conservative measures. XX indicated the medical necessity of proceeding with diagnostic medial branch blocks of L3, L4, L5 and S1 nerve bilaterally for the intensified pain and planned to submit for precertification again for medial branch blocks at the L3, L4, L5 and S1 bilaterally. He indicated that the patient was seen by a spine surgeon who had recommended an L1 to S1 fusion. The patient continued to work but was having difficulty doing so.

On XX/XX/XX, the patient was scheduled for medial branch nerve blocks at L3, L4, L5 and S1 bilaterally pending authorization.

Per XX Adverse Determination Notice dated XX/XX/XX, the request for bilateral medial branch nerve block at L3, L4, L5 and S1/fluoroscopy/sedation was denied with the following rationale: *“Based on the fact that the IW has had surgery at these levels and considering request is for more than 2 levels at one time, and considering lack of detailed discussion of prior treatment and injections over past xxxxx years, according to ODG (low back and pain) Treatment Guidelines; the request is not medically necessary”*

On XX/XX/XX, the patient reported recently the pain had increased to the lower back. He noted that the injection done at the last visit helped decrease the pain for a few weeks. He was frustrated with his ongoing pain and exacerbations. He reported when those exacerbations occurred, the pain could be so severe that he was bedridden. He was upset that the medial branch blocks were

denied. XX additionally assessed long-term drug use. XX requested medial branch blocks for two facet joint levels on either side. The patient was treated with Toradol and Depo-Medrol injection in the left gluteal region. He was advised to continue his pain medications. A UDS was ordered.

On XX/XX/XX, an unknown provider reviewed medical records which revealed XX established an maximum medical improvement (MMI) date of XX/XX/XX, and assigned the patient a whole person impairment rating (WPI) of 5%.

Per XX Adverse Determination After Reconsideration Notice dated XX/XX/XX, XX upheld the denial of the request for bilateral medial branch nerve block at L3, L4, L5 and S1/fluoroscopy/sedation with the following rationale: *“The request was previously non-certified noting that the patient has had surgery at these levels and the request was for more than two levels at one time. There is a lack of detailed discussion of prior treatment and injections over past xxxx years. The request is excessive as the Official Disability Guidelines note that no more than two levels should be injected. This claimant underwent prior facet injections; however, there is no specific information regarding this claimant’s objective functional response to injection therapy or if the patient subsequently underwent radiofrequency procedures. Additionally, there is no documentation of extreme anxiety to support sedation. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.”*

On XX/XX/XX, the patient was seen for continued low back pain follow-up. The patient was treated with Toradol and Depo-Medrol injection in the left gluteal region. He was to continue pain medications. He was advised to obtain a second opinion regarding treatment options.

On XX/XX/XX, the patient appealed for the denied services.

On XX/XX/XX, per XX Adverse Determination Notice, XX denied lumbar medial branch block at L3-S1/sedation/fluoroscopy with the following rationale: *“Based on the diagnosis and considering there has been prior lumbar surgery at these levels, and the very chronic nature of the complaints and the lack of detailed discussion of other injections over the past XX years, according to ODG (low back and pain) Treatment Guidelines, the request is not medically necessary.”*

On an unknown date, the patient requested for an IRO review of all his medical records and denials by XX.

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

The ODG provides concerning facet joint diagnostic blocks:

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)

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)

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) 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 be approximately 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.

Pertaining to previous surgical intervention, which was used for previous adverse determinations, the ODG specifically states: "in whom a surgical procedure is anticipated and in patients who have had a previous FUSION procedure". According to the records, the patient has a left laminotomy at the L34, L45 and L5S1 levels. The patient thus meets the criteria.

Furthermore, previous adverse determinations reasoned that the request was for more than 2 procedures at a time. The MBB (medial branch block) for the L45 and L5S1 facet joints includes the L3, 4, 5 and optional S1 medial branches. The total number of joints blocked remains at 2 (4 bilaterally). Thus, per the ODG, limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally (total of 4) and billed for only 4 total.

In regards to IV sedation, is not recommended and if anything other than agents such as midazolam are given, it would negate the diagnostic block. Furthermore, the patient should be off his opioids 4 hours prior and 4-6 hours post-injection.

In conclusion, the diagnostic Bilateral, L3, L4, L5 and S1 MBB are certified per the ODG criteria. However, the IV sedation is not certified unless anxiety is documented and only agents such as midazolam are used.

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

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**