



Specialty Independent Review Organization, Inc.

November 7, 2004

Hilda Baker
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M2-05-0208-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Medical Doctor who is board certified in Pain Management. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

According to medical records, ___ was initially injured on ___ while working as an electrician and lifting a heavy object. After this, he persisted with low back pain and was treated conservatively. The patient was diagnosed with a large L5-S1 disc herniation and underwent decompression, discectomy, and posterior fusion at L5-S1 on 09-26-00. After this, he completed work hardening and returned to work, although symptomatic. He then underwent an anterior interbody fusion at the same level on 01-25-02. He has referred improved radicular symptoms since the second surgery but persistent lumbar pain. His initial visit with Dr. B was on 06-24-02 in which he reported right-sided back pain with radiation to right thigh but primarily lumbar pain. He also referred right-sided groin pain. He has a history of cortisone injections in 2001 by Dr. K, per office notes. He recommended right SI joint block below the fusion. Dr. B noted on 07-21-04 (2 years later) that he has only managed the patient with medication since his initial

evaluation. He is prescribed: Norco, Flexeril, Ibuprofen, and Ambien. In this visit, he requested the procedures in question for diagnostic purposes and a possibility of eventual radiofrequency lesioning. An appeal letter from Dr. B states that the facet joints become pain generators in a post-fusion state. According to Dr. W, any psychosocial issues have been well addressed and the patient has coped well with full-time work although he continues with exacerbation of physical pain at the end of a workday.

According to imaging records, the patient did present with a large L5-S1 disc with S1 nerve compression pre-operatively. Postoperative imaging is limited to only MRI imaging which presents obvious artifact given his fusion hardware. Nonetheless, his most recent MRI of 07-12-04 reports pedicle screws and posterior rods in place at L5-S1 with multi-level facet hypertrophy at L2-L3, L3-L4 and L4-L5. There is also some report of facet hypertrophy and extensive scarring at L5-S1. No reports were provided regarding any EMG findings or CT scan imaging.

Office notes from Dr. B reflect that in May of 2004 the patient's pain medications had to be increased due to increased pain and he was referred to Dr. B for evaluation. He had persisted until this time with the right-sided low back pain with right lower extremity radiation as well as right SI joint pain. In October of 2003, he referred a recent fall at work with recent MVA as well. However, after this, his pain complaints remained the same as before. He had a previous right SI joint injection with Dr. K that provided weeks to one month of pain relief.

REQUESTED SERVICE

The items in dispute are the prospective medical necessity of facet injections, trigger point injection and Gray Ramus Communicans to be done in an ambulatory surgical outpatient setting.

DECISION

The reviewer disagrees with the previous adverse determination regarding recurrent medial branch blocks of the dorsal ramus on left L1, L2, L3 and L4.

The reviewer agrees with the previous adverse determination regarding interarticular zygapophysial joint injections, trigger point injections and an anesthetic block of gray ramus communicans.

BASIS FOR THE DECISION

In regards to the recurrent medial branch blocks, they are not medically necessary at this point in time. This patient has had anterior and posterior lumbar fusions at the L5-S1 level and he now presents with a chronic lumbar pain syndrome. This having been said, the patient has recuperated significant functional capacity with an active work status and low doses of medication. The patient has undergone extensive conservative treatment, but the remainder of his treatment is not well documented, or rather provided. No fusion operative reports or operative reports pertaining to any interventional pain management were provided. His recent diagnostics do show some

mild facet joint hypertrophy and according to his office notes, he does present with symptoms of a posterior element of pain as well as radicular pain symptoms.

The reviewer would deem medial branch blocks a medically necessary procedure to be done at the aforementioned levels of the recurrent medial branch. This, of course, would be for diagnostic purposes only to evaluate his candidacy for radiofrequency lesioning. Although, he does present with extensive treatment, the reviewer feels that he is entitled to pain management for his residual chronic pain syndrome. The indication for lumbar medial branch blocks is to determine if the patient presents with pain generation from the medial branch of the lumbar dorsal rami. Lumbar medial branch blocks provide diagnostic information and if therapeutic results are obtained, then there is medical probability that the patient would have a positive response to radiofrequency neurotomy. The reviewer does feel that due to his extensive fusion at the L5-S1, he could be experiencing increased pain from the facet joints, which is to be tested with this procedure. The reviewer believes that a three level test is within standard medical practice and therefore, these levels will be approved. This does fall within the guidelines for diagnostic medial branch blocks.

In regards to the remaining requested procedures, the reviewer does not feel that these can be medically justified at this time. The trigger point injections requested with the medial branch blocks will be palliative at best and would not provide any significant therapeutic benefit. In addition, the diagnostic benefit of the medial branch blocks will be ineffective if several pain generating sites are targeted at one time. The indication for medial branch blocks is to determine precise levels of pain generation. If this is so, a definitive response to a medial branch block cannot be determined if the trigger point injections provides some degree of pain relief.

The interarticular zygapophysial joint injections are also not warranted at this time. These injections could provide some temporary relief for the patient; however, the prime objective of the medial branch blocks is to localize pain and determine if the patient would benefit from radiofrequency neurotomy. According to treatment guidelines (1), the medial branch block is the procedure that is appropriate to determine the necessity of radiofrequency neurotomy. Again, if the interarticular block provides pain relief this would still interfere with any documented response from the medial branch block.

The reviewer has also studied the possible indication for a block of the gray ramus communicans. According to studies mentioned by Dr. B, there are several investigations realized by Dr. N regarding nerve involvement at various lumbar levels. In one specific study (1), the conclusion determined that the innervation of the facet joints included not only dorsal root ganglia in addition to paravertebral sympathetic ganglia to the levels of L1 and L2 dorsal root ganglia. Unfortunately, this study is an academic study and not an actual case study in which this procedure was tested. The possibility does exist that this block could provide some therapeutic benefit in terms of facet joint innervation; however, I must refer once again to the objective of the procedure. Whether or not the block of the gray ramus communicans provides the patient with pain relief, it would still not affect the outcome of determination for possible radiofrequency neurotomy. The medial branch block continues to be the definitive procedure for

progression towards this neurotomy and a positive block of the gray ramus would overlay the response of the medial block itself.

- References:** (1) Suseki, et al (including Shinichiro N). *Innervation of the Lumbar Facet Joints: Origins and Functions*. Spine. 22(5): 477-485, March 1, 1997.
- (2) ISIS Treatment Guidelines for lumbar medial branch block by Nikolai Bogduk, M.D.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 17787, Austin, TX 78744. The fax number is 512-804-4011. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(u)(2).

Sincerely,

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 8th day of November, 2004

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: