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IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar facet block L5-S1 medial branch bilaterally x one (64493 x 2, 64494 x 2, 77003, J2250, J2201, 01992) and cervical facet block C2-C3 and C3-C4 medial branch bilaterally x one (64490 x 2, 64491 x 2, 64492, 77003, 01992, J3301, J2250)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
American Board of Physical Medicine & Rehabilitation
American Board of Pain Medicine

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

☒ Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX who was injured on XX, when XX was XX. The patient was diagnosed with cervical and lumbar sprain/strain and radiculopathy.

From XX, through XX, the patient was seen by several physicians and was diagnosed with cervical and lumbar strain with radiculopathy, C4-C5 and C5-C6 cervical disc displacement with radiculopathy. On XX, a magnetic resonance imaging (MRI) of the cervical spine was performed at XX Imaging and interpreted by XX, M.D. The study showed a 4 mm paracentral disc herniation of the right was present at C4-C5 with lateral recess encroachment. There were small diffuse disc herniations present at C5-C6. Otherwise, the study was negative. The treatment included medications, therapy and cervical epidural steroid injection (ESI). On XX, XX, M.D., evaluated the patient for medical clearance of neck surgery which was scheduled on XX. The patient continued to complain of neck pain, located in the right posterior and lateral neck. The pain radiated into the right trapezius, right shoulder and right upper arm. On exam, there was pain/stiffness in the neck. On XX, x-rays of the chest showed complete atelectasis of the left upper lobe with volume loss in the left hemithorax. The fullness of the left hilum suggested adenopathy.

On XX , XX M.D./XX, M.D. saw the claimant patient for neck pain. It was noted that as the chest x-rays were positive for cancer, spotted in the left upper lung field. XX had been undergoing chemotherapy for

cancer. On exam, the patient was in moderate distress and had stiffness in the neck. The patient had significant difficulties with the physical requirements of XX job. The diagnoses were radiculopathy, cervical disc disorder and malignant neoplasm of the upper lobe of the left lung. An impairment Rating (IR) referral was provided.

On XX, XX evaluated the patient for neck and lower back pain, rated at 4/10. The patient had been seeing XX for pain management and had been treated for XX lung cancer. The main pain was in the neck and the back and did bother XX on occasions but not always. The examination showed tenderness in the cervical spine and at L3, L4 and L5. Limited ROM of the cervical spine was noted. Off work status was maintained.

On XX, and XX, XX noted no change in the neck and low back pain. The patient stated that XX was 0% better since the injury. XX reported nothing helped to control the pain. XX still had constant pain and felt depressed. On exam, XX was guarded and not moving XX back or neck. XX was prescribed. Pain Management referral was provided.

On XX, XX, M.D., evaluated the claimant patient for neck and back pain worse with rotating neck and back. The cervical spine examination revealed decreased ROM in flexion, extension and rotation, spasms and pain in the bilateral C2-C3 and C3-C4 facet. The lumbar spine examination revealed decreased flexion, extension and rotation, bilateral spasms and pain at the L5-S1 facets. There was poor toe and heel walking. The patient was using a cane for ambulation. The diagnoses were lumbar and cervical sprain/strain. XX recommended bilateral C2-C3 and C3-C4 and bilateral L5-S1 medial branch blocks (MBB), PT and radiofrequency ablation (RFA).

On XX, XX noted no changes in the patient's condition. The cervical and lumbar facet blocks approval was pending.

Per Utilization Review dated XX, the request for lumbar facet blocks at L5-S1, cervical facet blocks at C2-C3 and C3-C4 MBB was denied on the basis of the following rationale: "*There must be a detailed history and thorough exam documented to support symptomatic facet arthropathy and the need for these injections. There is no history and exam were provided. Recommend non-certification for the request of lumbar facet blocks L5-S1 MBB and cervical facet blocks C2-3, C3-4 MBB."*

Per Reconsideration dated XX, the request for lumbar and cervical facet blocks was denied. Rationale: "*ODG notes that for cervical and lumbar medial branch blocks/facet blocks to be indicated, the clinical presentation should be consistent with facet joint pain. In this case, the claimant has ongoing neck and back pain; however, clinical presentation is not consistent with facet joint pain. There is no evidence of facet joint tenderness or positive facet maneuvers on examination to suggest the facets of the possible pain generator. There is no objective clinical evidence of facet-mediated isolated restriction of cervical range of motion that might not be similarly explained by myalgia of the paravertebral soft tissue structures. Furthermore, there is no evidence of facet arthropathy on imaging studies to support this request; however, the background medical literature relating to facet-mediated pain notes, there is no reliable correlation between imaging findings and the facet joints being pain generators. Therefore, the requested cervical and lumbar facet joint blocks are not supported as medically necessary*."

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

According to ODG, "Criteria for use of therapeutic intra-articular and medial branch blocks are as follows:

1. No more than one therapeutic intra-articular block is recommended
2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion
3. If successful (initial relief of 70%, plus pain relief of at least 50% for a duration of at least 6

weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neruotomy (if the medial branch block is positive).
4. No more than 2 joint levels may be blocked at any one time
5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection.

The ODG does not support facet injection/medial branch block in this clinical context. The patient has evidence of radiculopathy documented since XX. The most recent clinical notes are not consistent with previous notes. The history and physical examination lack documentation of pertinent positive or negative signs and symptoms of radiculopathy. However, it is noted that "There was poor toe and heel walking", which may be a sign of weakness, which is consistent with radiculopathy and not facet mediated pain.

In addition, the CPT codes are incorrect for the requested procedure. For medial branch blocks, the proper billing is to bill for each complete facet joint blocks (see example below)

- Bilateral L5S1 facet joint- The MBBs would be billed as 64493 -50. In order to block/denervate the L5/S1 facet from the example above, you would need to do MBB/RFA on the L4 and L5 medial branches. The S1 is optional but not billable.
- Bilateral C2/3, C3/4 (Two full facet joints)- TON (partially innervated C23), C3, C4, blocks are billed as 64490-50 and 64491-50
- Fluoro can NOT be billed separately for these.

Thus the requested procedures are not certified at this time and are not medically necessary.

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