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Description of the service or services in dispute:

XX

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified PMR and Board Certified Pain Management

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

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

Patient Clinical History (Summary)

XXXX and had been off work since that time. XXXX. XXXX was diagnosed with XX, XX and XX at XX level, XX; XX, initial XX; strain of XX, XX, and XX arm level, XX arm, initial XX; other specific joint derangements of XX shoulder, not elsewhere classified (XX.XX);and XX muscles, XX, and XX and XX arm level, XX arm, initial encounter XX.

XXXX. XXXX presented for XX pain, which radiated to the XX XX extremity. XXXX stated the pain was excruciating at times, worse with turning XXXX XX and with plane journey. XXXX complained of numbness / tingling in the XX XX extremity. On examination, XX range of motion revealed decreased flexion and decreased rotation to the XX and to the left. XXXX had XX facet pain in the XX XX-XX, XX-XX medial branch facet and paravertebral spasms.

The treatment to date included medications including XXXX; ice application; and physical therapy without any significant relief. The physical therapy aggravated XXXX symptoms.

An MRI of the XX shoulder dated XXXX, demonstrated marked XX with XX tear; XX with XX tear, and associated small ganglion cyst at XX; XX and XX; XX; XX; and XX. X-rays of the XX XX dated XXXX,

XX of XX on XX and XX mm XX of XX on XX. The XX spaces showed marked narrowing and spurring at XX-XX. The XX-XX anterolisthesis XX. XX was noted.

Per a utilization review decision letter dated XXXX and a peer review by XXXX, the request for XX XX-XX, XX-XX medial branch blocks with physical therapy 2x1 of the XX XX to follow, was denied. Rationale: "The request for XX XX/XX, XX/4 medial branch blocks (MBB) with physical therapy (PT) XX x 1 is not medically necessary, medically appropriate, or indicated here. As noted in ODG's XX and XX XX Chapter Facet Joint Diagnostic Blocks topic, facet blocks should be employed as a precursor to pursuit of facet neurotomy procedures, a procedure which ODG deems under study. Here, since the request for medial branch blocks represents a precursor to pursuit of a procedure which ODG deems under study, the request is not indicated. ODG further notes that such blocks, if performed, should be reserved for claimants with a presentation suggestive of facetogenic pain in individuals whose presentation is in fact non-radicular in nature. Here, however, the claimant's superimposed XX radicular symptoms effectively called into question the presence of bona fide XX for which the medial branch blocks in question could be considered, per ODG. The medial branch block component of the request is not, thus, indicated. Since that component of the request is not indicated, the concomitant request for physical therapy is likewise not indicated. Therefore, the request for XX XX/XX, XX/XX medial branch blocks (MBB) with PT XX x 1 is not medically necessary, medically appropriate, or indicated here."

Per a utilization review decision letter dated XXXX and a peer review by XXXX, the prior denial was upheld. Rationale: "The request for Appeal XX Facet medial branch blocks injections at XX/XX, XX/XX x 1 is not medically necessary. The claimant is XX months status post XX sprain/strain injury with radiating pain to XX XX extremity. XXXX has failed conservative treatment with continued pain. Clinical findings of decreased XX range of motion with facet pain XX/XX and XX/XX with medial branch facet paravertebral spasms. XX MRI findings pending, no findings for shoulder MRI. Request is for an initial diagnostic block. In that the guidelines noted there should be no evidence of radicular pain and/or XX stenosis, and noting that the physician is indicating possible treatment with epidural injection or rhizotomy procedure, and XX MRI findings have not been reviewed or performed, the request is not supported. The guidelines require imaging prior to proceeding to the procedures. This request is not supported as medically necessary."

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

Based on the clinical information provided, the request for XX facet blocks at XX-XX, XX-XX medial branch on the XX times one is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review decision letter dated XXXX and a peer review by XXXX, the request for XX XX-XX, XX-XX medial branch blocks with physical therapy 2x1 of the XX XX to follow was denied, noting that in ODG's XX and XX XX Chapter Facet Joint Diagnostic Blocks topic, facet blocks should be employed as a precursor to pursuit of facet neurotomy procedures, a procedure which ODG deems under study. Here, since the request for medial branch blocks represents a precursor to pursuit of a procedure which ODG deems under study, the request is not indicated. ODG further notes that such blocks, if performed, should be reserved for claimants with a presentation suggestive of facetogenic pain in individuals whose presentation is in fact non-radicular in nature. Here, however, the claimant's superimposed XX radicular symptoms effectively called into question the presence of bona fide

XX for which the medial branch blocks in question could be considered, per ODG. The medial branch block component of the request is not, thus, indicated. Per a utilization review decision letter dated XXXX and a peer review by XXXX dated XXXX, the prior denial was upheld noting that the claimant is XX months status post XX sprain/strain injury with radiating pain to XX XX extremity. XXXX has failed conservative treatment with continued pain. Clinical findings of decreased XX range of motion with facet pain XX/XX and XX/XX with medial branch facet paravertebral spasms. XX MRI findings pending, no findings for shoulder MRI. Request is for an initial diagnostic block. In that the guidelines noted there should be no evidence of radicular pain and/or XX stenosis, and noting that the physician is indicating possible treatment with epidural injection or rhizotomy procedure, and XX MRI findings have not been reviewed or performed, the request is not supported. The guidelines require imaging prior to proceeding to the procedures. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient has been referred for a XX MRI; however, it is unclear if this was authorized and/or performed. Current evidence based guidelines note that the requested procedure is limited to patients with XX pain that is non-radicular. This patient presents with radiating pain in a nerve root distribution. There is no documentation of severe anxiety or needle phobia to support the use of sedation. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic XX XX Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines

Recommended prior to facet neurotomy (a procedure that is considered "under study").

Criteria for the use of diagnostic blocks for facet nerve pain:

Clinical presentation should be consistent with <u>facet joint pain, signs & symptoms</u>.

1. One set of diagnostic medial branch blocks is required with a response of ≥ 70%. The pain response should be approximately XX hours for XX.

XX. Limited to patients with XX pain that is non-radicular and at no more than two levels bilaterally.

XX. 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 XX 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, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy.

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 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.
11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.
12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.

Diagnostic blocks are 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 MBB. 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 27% to 63%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself.

Technique: The described technique of blocking the medial branch nerves in the XX-XX region (XX-X, XX-X XX-X, and XX-XX) is to block the named medial branch nerves (two injections). Authors have described blocking XX-XX by blocking XX nerve. Another technique of blocking XX-XX is to block at three injection points (vertically over the joint line, immediately above the inferior articular facet at XX and immediately below the superior articular facet at XX). (Barnsley, 1993) The medial branch nerve innervates the facet joint, facet capsular ligaments, the interspinous and supraspinous ligaments, spinous processes and paraspinal muscles. Relief of pain could be due to blockade of nociceptive input from any combination of these. It is suggested that the volume of injectate for diagnostic medial branch blocks be kept to a minimum (a trace amount of contrast with no more than 0XX) as increased volume may anesthetize these other potential areas of pain generation and confound the ability of the block to accurately diagnose facet pathology. A recent study has recommended that the volume be limited XX.

Epidemiology of involved levels: Using cadaver evidence facet arthrosis most commonly affects the XX XX levels, and increased with age, and was very rare in patients less than XXyears of age. XX-5 is the most common level followed by XX-4 and XX-XX. This study did not attempt to identify number of levels of involvement. (Lee, 2009)

Number of levels of involvement: In a randomized controlled trial of therapeutic XX medial branch blocks it was stated that XX had XX joints involved and XX joints involved. (Manchikanti, 2008) These levels were identified by the pain pattern, local or paramedian tenderness over the area of the facet joint, and reproduction of pain to deep pressure.

(Manchikanti, 2004) Other prevalence studies from this group also indicated that the majority of patients with XX involvement were treated at three joints. Target joints were identified as noted above. (Manchikanti, 2004). There are no studies that have actually tested levels of involvement using individual injections for diagnostic verification. (Lord, 1996) (Washington, 2005) (Manchikanti , 2003) (Dreyfuss, 2003) (Falco, 2009) (Nordin, 2009) (Cohen, 2010) See the Low XX Chapter for further references.

Complications: See Facet joint therapeutic steroid injections.

- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.