Becket Systems

An Independent Review Organization
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Description of the service or services in dispute:
XX XX-XX and XX-XX level /XX of the XX.
XX
XX
XX
XX
XX

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified Pain Medicine and Physical Medicine and Rehabilitation

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 who was diagnosed with sprain of XX, initial encounter (XX). On XXXX, XXXX. XXXX had pain to the whole body but specifically XXXX thighs, XX, and XX knee.

XXXX for XX pain. XXXX reported XXXX was able to stand / sit / walk for less than 30 minutes. The pain was described as aching and stabbing and rated as 7-9/10. On XX examination, there was XX on XX rotation, extension and palpation and XX loading in the XX XX. The pain was noted at the XX bilaterally at the level of XX-XX and XX-XX with spasms.

An MRI of the XX XX dated XXXX showed moderately-severe compromise of the XX canal at XX-XX secondary to XX and a broad-based XX-mm disc herniation, which slightly compressed the XX contributing to the compromise of the XX canal and did not affect the XX.

The treatment to date included medications (XXXX), physical therapy, and XX epidural XX injection XX (50% improvement in pain).

Per a utilization review decision letter and peer review dated XXXX, the requested service was denied by XXXX. Based on the documentation provided and per the ODG guidelines, the requested service was not medically necessary. Though there was documentation of XXXX had positive XX pain on examination, there was no documentation of having trial and failure of conservative therapy. An MRI showed moderately-severe compromise of the XX XX XX-XX that was secondary to XX and broad-based XXmm XX herniation, which compressed the XX and contributed to the compromise of the XX XX and did not affect the XX. Per ODG, there would be no evidence of radicular pain, XX XX or previous XX. Therefore, the request was not certified.

Per a utilization review decision letter dated XXXX and peer review dated XXXX, the prior denial was upheld by XXXX. Rationale: "ODG guidelines support the utilization of XX blocks for XX pain not adequately benefitted from conservative measures that were non-radicular and at no more than two levels bilaterally. In this case, XXXX has radicular complaints with imaging indicating XX XX. Therefore, the request is not 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 XX block XX-XX and XX-XX level /XX branch of the XX x1, XX - Injection(s), diagnostic or therapeutic agent, XX XX (XX) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), XX or XX, XX - Injection(s), diagnostic or therapeutic agent, XX XX (XX) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), XX or XX - XX, XX - Anesthesia for procedures in XX region, XX - Injection, XX, per XX, XX - Anesthesia for other procedures is not recommended as medically necessary. Per a utilization review decision letter and peer review dated XXXX, the requested service was denied by XXXX. Based on the documentation provided and per the ODG guidelines, the requested service was not medically necessary. Though there was documentation of XXXX had positive XX pain on examination, there was no documentation of having trial and failure of conservative therapy. An MRI showed moderately-severe compromise of the XX canal at XX-XX that was secondary to hypertrophy and broad-based XX-mm XX herniation, which compressed the XX and contributed to the compromise of the XX canal and did not affect the XX. Per ODG, there would be no evidence of radicular pain, XX XX or previous fusion. Therefore, the request was not certified. Per a utilization review decision letter dated XXXX and peer review dated XXXX, the prior denial was upheld by XXXX. Rationale: "ODG guidelines support the utilization of XX blocks for XX pain not adequately benefitted from conservative measures that were non-radicular and at no more than two levels bilaterally. In this case, XXXX has radicular complaints with imaging indicating XX XX. Therefore, the request is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The submitted clinical records indicate that the patient has been determined to have reached maximum medical improvement as of XXXX with 0% whole person impairment. The patient presents with a diagnosis of sprain of ligaments of the XX XX. The patient continues to work full duty without restrictions. There is no documentation of any recent active treatment. 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 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
XX Chapter: XX Injections

Diagnostic: Recommend no more than one set of XX diagnostic blocks prior to XX 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 XX neurotomy at the diagnosed levels.

Criteria for the use of diagnostic blocks for XX "mediated" pain:
Clinical presentation should be consistent with XX joint pain, signs & symptoms.
1. One set of diagnostic XX branch blocks is required with a response of ≥ 70%. The pain response should last at least 2 hours for XX.
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 XX) prior to the procedure for at least 4-6 weeks.
4. No more than 2 XX joint levels are injected in one session (see above for XX 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 XX blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)
11. Diagnostic XX blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)]
Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a XX 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 XX found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the XX. 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) (Cohen, 2007) (Mancchukonda, 2007) (Dreyfuss, 2000) (Manchikanti2, 2003) (Datta, 2009)
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) The use of sedation during diagnostic injections may increase the rate of false-positive blocks and lead to misdiagnoses and unnecessary procedures, but has no effect on satisfaction or outcomes at 1-month. (Cohen, 2014)
MBB procedure: The technique for XX branch blocks in the XX region requires a block of 2 XX branch nerves XX (Clemans, 2005) The volume of injectate for diagnostic XX 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 XX 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, 2004) (Pneumaticos, 2006) (Boswell, 2007) (Boswell2, 2007) A recent meta-analysis concluded that there is insufficient evidence to evaluate validity or utility of diagnostic selective nerve root block, intra-articular XX joint block, XX branch block, or sacroiliac joint block as diagnostic procedures for low back pain with or without radiculopathy. (Chou2, 2009) This study suggests that proceeding to radiofrequency denervation without a diagnostic block is the most cost-effective treatment paradigm, but does not result in the best pain outcomes. (Cohen, 2010)

Therapeutic: Under study. Current evidence supporting this procedure is conflicting, and at this time, no more than one therapeutic intra-articular block is suggested. If this treatment is successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a XX branch diagnostic block and subsequent neurotomy (if the XX branch block is positive). If a therapeutic XX joint block is undertaken, it is suggested that it be used in concert with other evidence-based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti, 2003) (Boswell, 2005)
See XX joint diagnostic blocks (injections); XX joint pain, signs and symptoms; XX joint radiofrequency neurotomy; XX joint XX branch blocks (therapeutic injections); and Segmental rigidity (diagnosis). See also the Neck Chapter and Pain Chapter.
Criteria for use of therapeutic intra-articular and XX 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, XX stenosis, or previous fusion.
3. If successful (initial pain 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 XX branch diagnostic block and subsequent neurotomy (if the XX 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 XX joint injection therapy.
In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid XX joint injections, they remain a popular treatment modality. Intra-articular XX joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews, as their benefit remains controversial. The therapeutic XX joint injections described here are injections of a steroid (combined with an anesthetic agent) into the XX joint under fluoroscopic guidance to provide temporary pain relief. (Dreyfuss, 2003) (Nelemans, 2000) (Carette, 1991) (Nelemans, 2001) (Slipman, 2003) (van Tulder, 2006) (Colorado, 2001) (ICSI, 2004) (Bogduk, 2005) (Resnick, 2005) (Airaksinen, 2006) An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy. (Staal, 2009)
Systematic reviews endorsing therapeutic intra-articular XX blocks:
Pain Physician, 2005: In 2005, there were two positive systematic reviews published in Pain Physician that stated that the evidence was moderate for short-term and limited for long-term improvement using this intervention. (Boswell, 2005) (Boswell, 2005) These results were based, in part, on five observational studies. These non-controlled studies were confounded by variables such as lack of confirmation of diagnosis by dual blocks and recording of subjective pain relief, or with measures that fell under verbal rating and/or pain relief labels (measures that have been reported to have problems with validity). (Edwards, 2005)
Pain Physician, 2007: Pain Physician again published a systematic review on this subject in 2007 and added one additional randomized trial comparing intra-articular injections with sodium hyaluronate to blocks with triamcinolone acetonide. The diagnosis of XX osteoarthritis was made radiographically. (Fuchs, 2005) Two randomized trials were not included, in part because they failed to include controlled diagnostic blocks. These latter articles were negative toward the use of therapeutic XX blocks. (Lilius, 1989) (Marks, 1992) An observational non-controlled study with positive results was included that made the diagnosis of XX XX syndrome based on clinical assessment of "pseudoradicular" XX pain, including evidence of an increase of pain in the morning and with excessive stress and exercise (no diagnostic blocks were performed). (Schulte, 2006) With the inclusion of these two articles, the conclusion was changed so that the evidence for XX intra-articular injections was "moderate" for both short-and long-term improvement of low back pain. (Boswell2, 2007)
Complications: These included suppression of the hypothalamic-pituitary-adrenal axis for up to 4 weeks due to steroids with resultant elevated glucose levels for less than a week. (Ward, 2002) There have been rare cases of infection (septic arthritis, epidural abscess and meningitis). (Cohen, 2007) Complications from needle placement include dural puncture, XX cord trauma, intra-arterial and intravenous injection, XX anesthesia, neural trauma, pneumothorax, and hematoma formation. (Boswell2, 2007)
Single photon emission computed tomography: (bone scintigraphy, SPECT scan): Not recommended, although recent research is promising. This technique is recommended based on the ability of radionuclide bone scintigraphy to detect areas of increased function, depicting synovial areas of inflammation as well as degenerative changes. Thirteen of 15 patients had a > 1 standard deviation pain score improvement at 1 month versus 7 of 32 patients with a negative

or no scan. The benefit of the injection lasted for approximately 3 months and did not persist to 6 months. (Pneumaticos2, 2006)

- ☐ 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.