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DATE OF REVIEW: OCTOBER 26, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient lumbar facet blocks and possible radiofrequency facet denervation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified Orthopaedic Surgeon

REVIEW OUTCOME

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

Overturned (Disagree)

Medical documentation supports the medical necessity of Outpatient lumbar facet blocks and possible radiofrequency facet denervation

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Attorneys at Law

- Utilization reviews (09/14/07 – 10/02/07)
- ODG guidelines on lumbar facet blocks

M.D.

- Office notes (01/25/07 - 10/08/07)
- Radiodiagnostics and neurodiagnostics (01/27/07 - 08/22/07)

ODG Guidelines are cited in the denials

PATIENT CLINICAL HISTORY [SUMMARY]:

This is heavy equipment mechanic who was picking up and toting a track roller that weighed about 250 lbs. He kneeled down to place the roller down when he had instant pain in his lower back and left knee.

M.D., saw the patient for midline low back pain, prescribed Celebrex, and recommended a lumbar epidural steroid injection (ESI). Magnetic resonance imaging (MRI) revealed spondylosis at L4-L5 with mild central canal stenosis and mild bilateral lateral recess and foraminal stenosis. The patient did not improve with the lumbar ESI. Dr. assessed possible lumbar facet syndrome and recommended chiropractic manipulation.

M.D. obtained x-rays of the left knee that revealed mild loss of the articular cartilage height in the medial compartment. An MRI scan revealed horizontal tear of the posterior horn of the medial meniscus. Dr. recommended left knee arthroscopy.

F.N.P., noted Dr. had performed left knee arthroscopic surgery. The patient was treated with 28 visits of chiropractic therapy with no significant pain relief. He was on Lyrica. Ms. prescribed Lortab and recommended further diagnostics. Electromyography/nerve conduction velocity (EMG/NCV) study of the upper extremities revealed bilateral carpal tunnel syndrome (CTS), bilateral ulnar neuropathy at the wrist (Guyon's canal), and sparse acute denervation in the C5-C6 innervated muscles suggesting irritation involving these root levels on the right. EMG/NCV studies of the lower extremities were unremarkable.

MRI of the cervical spine revealed: (1) Mild encroachment upon the right C2-C3 neural foramen. (2) Mild encroachment upon the right C3-C4 neural foramina secondary to uncinata joint hypertrophy with early posterior osteophyte formation. (3) Encroachment upon the C4-C5 neural foramen, right greater than left, secondary to uncinata and facet hypertrophy. (4) Prominent degenerative disc disease (DDD) at C5-C6 with mild spinal canal compromise and mild encroachment upon the C5-C6 neural foramina secondary to bony hypertrophy. (5) Mild spinal canal compromise at C6-C7 secondary to posterior osteophyte formation with moderate encroachment upon the right C6-C7 neural foramina secondary to bony hypertrophy. (6) Minimal ventral disc protrusion at C7-T1 slightly effacing the thecal sac with mild encroachment upon the C7-T1 neural foramina bilaterally secondary to bony hypertrophy.

MRI of the lumbar spine revealed: (1) Mild DDD at L2-L3 with facet and ligamentum flavum hypertrophy slightly encroaching upon the posterior lateral aspect of the thecal sac. (2) Facet and ligamentum flavum hypertrophy at L3-L4 with mild encroachment upon the thecal sac from the posterior lateral aspect bilaterally. (3) Broad-based disc bulge at L4-L5 superimposed upon rather extensive facet and ligamentum flavum hypertrophy. This combination of findings was associated with moderate spinal canal compromise at L4-L5 level. (4) Broad-based disc bulge at L5-S1 asymmetric to the left superimposed upon rather advanced DDD. There was mild spinal canal compromise secondary to this combination of findings slightly asymmetric to the left.

M.D. reviewed the radiodiagnostics and recommended lumbar facet blocks with possible radiofrequency from L3-L4 through L5-S1 bilaterally.

In a utilization review, lumbar facet blocks were denied with the following rationale: *The clinical information suggested that the patient continued to describe multiple complaints reportedly related to lumbar and cervical spondylosis, CTS, ulnar nerve entrapment, and lumbar facet syndrome. In light of the plethora of musculoskeletal diagnoses as well as limited clinical information available that did not document the extent of his conservative treatment, a more comprehensive physical examination, and/or description of imaging studies thus far, the proposed facet blocks could not be recommended as reasonable and necessary. He had non-myelopathic give way weakness which could on some occasions be considered non-physiologic.*

A reconsideration request for the lumbar facet blocks was denied with the following rationale: *The patient was diagnosed with lumbar and cervical spondylosis without myelopathy in addition to carpal tunnel syndrome, ulnar nerve entrapment, and facet loading syndrome. According to ODG, lumbar facet injections are recommended at no more than two joint levels at one time. With regards to the request for radiofrequency denervation, there is not enough information to render a decision of medical necessity. This procedure depends on the patient's results of the diagnostic lumbar facet blocks which are still pending for him.*

On October 8, 2007, Dr. recommended lumbar discogram/computerized tomography (CT) from L2 through S1 to decide further line of treatment.

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

MR. HAS A LONG HISTORY OF LOW BACK PAIN FOLLOWING HIS INJURY HAS UNDERGONE EXTENSIVE CONSERVATIVE TREATMENT WITHOUT PAIN RESOLUTION. HE HAS RADIOGRAPHIC EVIDENCE OF SIGNIFICANT LUMBAR FACET SPONDYLOSIS AND HAS BEEN DIAGNOSED WITH LUMBAR FACET SYNDROME BY TWO SEPARATE, INDEPENDENT ORTHOPAEDIC SURGEONS. FACET INJECTIONS, WITH POSSIBLE SUBSEQUENT RADIOFREQUENCY FACET ABLATION BASED ON THE PATIENTS RESPONSE TO THE INJECTIONS IS CERTAINLY INDICATED AT THIS POINT. AS POINTED OUT BY DR., THESE INJECTIONS AND POSSIBLE ABLATION ARE BEING PERFORMED IN AN ATTEMPT TO AVOID MORE EXTENSIVE SURGICAL INTERVENTION. WHILE ODG RECOMMENDS INJECTIONS AT NO MORE THAN TWO JOINT LEVELS AT ONE TIME, FACET INJECTIONS ARE COMMONLY PERFORMED AT MORE THAN TWO LEVELS AND THE PATIENTS RESPONSE DOCUMENTED. BASED ON THE RESULTS OF THE INJECTIONS, FACET NEUROLYSIS IS A REASONABLE AND NECESSARY PROCEDURE TO PERFORM FOR MR.

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

CLINICAL EXPERIENCE AS A BOARD CERTIFIED ORTHOPAEDIC SURGEON WAS UTILIZED DURING THIS REVIEW. IN ADDITION, STANDARD ORTHOPAEDIC SPINE SURGERY TEXTBOOKS AND ODG WERE CONSULTED PRIOR TO ARRIVING AT THIS DECISION.

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**