

# P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

## Notice of Independent Review Decision

**DATE OF REVIEW:** November 18, 2008

**IRO CASE #:**

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

This case was reviewed by a PM & R (Board Certified) doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Lumbar facet injections L3-4, L4-5, L5-S1 with phenol

### **REVIEW OUTCOME**

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

Upheld (Agree)

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o April 29, 2008 lumbar discogram and CT report from , M.D.
- o April 7, 2008 through September 3, 2008 medical records from
- o March 21, 2008 lumbar myelogram and post-myelogram CT report by M.D.
- o June 24, 2008 operative report by , M.D.
- o September 2, 2008 utilization review report from
- o October 20, 2008 utilization review report from
- o March 12, 2008 through September 22, 2008 medical records from , M.D.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records, the patient sustained an industrial injury on xx/xx/xx. A March 12, 2008 neurosurgical consultation report states that the patient is a xx year-old female who presents with low back pain radiating into the lower extremities. She has undergone chiropractic treatments with no improvement. She has also undergone a lumbar epidural steroid injection without any improvement. A lumbar myelogram was recommended.

On March 24, 2008, the results of the lumbar myelogram were reviewed with the patient and the physician stated that he does not feel that the abnormal findings are the etiology of her symptoms. She complains of more back pain than leg pain. A discogram was recommended. The discogram revealed reproduction of concordant pain from all three injections at L3-4, L4-5, and L5-S1. There was disruption of the disc architecture at all three levels. Given that there is usually a poor surgical outcome in addressing three-level intervertebral disc disease, the physician recommended a trial of lumbar facet injections. If the diagnostic injections are successful, the treatment plan includes a more permanent injection with phenol.

A July 7, 2008 report states that the patient underwent bilateral lumbar facet injections at L3-4, L4-5, and L5-S1 on June 24, 2008. These injections were specifically administered to the facet joints with Depo-Medrol and 0.5% Marcaine. The leg pain that she was experiencing had markedly decreased and she had noticed at least a 40% reduction in her low back pain. Since she had a significant decrease in pain, the physician recommended that she undergo physical therapy. On August 25, 2008, the patient stated that she has attended seven sessions of physical therapy and began experiencing an increase in her back pain. Lumbar

facet injections with phenol were recommended as this would give her longer lasting relief since the previous injections were diagnostic.

The request was reviewed on September 2, 2008 and a non-certification rendered. The report states that there was no physical examination as of the last note. The nurse had informed the physician reviewer that the patient had L3-S1 facet joint injections with 40% relief reported. The Official Disability Guidelines (ODG) were quoted. The conclusion stated that the physician is proposing a chemical radiofrequency ablation with phenol. This is considered an unproven procedure per ODG according to the report. The ODG guidelines also recommend treating up to only two joint levels at a time according to the physician reviewer.

A September 22, 2008 request letter was submitted by the physician. The letter outlines the treatment history and medical documentation. The letter notes that on July 21, 2008, the patient was seen by the physical therapist. The physical therapist noted that the patient has been able to complete 11 visits of physical therapy beginning on July 21, 2007 and completed on September 3, 2008. Although the patient has been able to decrease her pain and improve her function slightly, she still needs the opportunity to transition to land activities so she can be prepared and physically able to pass her functional capacity evaluation. The physician noted that the patient has indeed undertaken lumbar facet blocks which were diagnostic in nature. These were successful and it is appropriate for the patient to undertake the request of lumbar facet injections with phenol according to the letter.

The case was again reviewed on October 20, 2008 and another non-certification rendered. The report states that the patient only had 40% reduction in pain following the facet injections. The proposed procedure consists of a chemical rhizolysis at these levels which is not supported by current evidence-based guidelines.

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

As noted above, the patient underwent lumbar facet injections at the L3-4, L4-5, and L5-S1 levels on June 24, 2008. Approximately two weeks later, she was seen and reported 40% relief. As noted in the Official Disability Guidelines, diagnostic injection should consist of a medial branch block with the response of greater than or equal to 70% in order to be considered successful. The records fail to document that the medial branch block was performed with such a percentage pain relief. Most importantly, the guidelines do not recommend facet joint chemical rhizotomy as it is considered experimental. When appropriate facet joint radiofrequency neurotomy is indicated, the guidelines recommend that these be administered at only two joint levels rather than the requested three joint levels. Based on a review of the guidelines, the patient is not a candidate for facet joint radiofrequency neurotomy and certainly not a candidate for chemical rhizotomy, as it is considered experimental. Therefore, my determination is to uphold the previous determinations of non-certification for the request of lumbar facet injections L3-4, L4-5, L5-S1 with phenol.

The IRO's decision is consistent with the following guidelines:

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

\_\_\_\_ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

\_\_\_\_ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

\_\_\_\_ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

\_\_\_\_ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

\_\_\_\_ INTERQUAL CRITERIA

\_\_\_\_ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

\_\_\_\_ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

\_\_\_\_ MILLIMAN CARE GUIDELINES

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

\_\_\_\_ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

\_\_\_\_\_ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

\_\_\_\_\_ TEXAS TACADA GUIDELINES

\_\_\_\_\_ TMF SCREENING CRITERIA MANUAL

\_\_\_\_\_ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

\_\_\_\_\_ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

Official Disability Guidelines (2008):

Facet joint chemical rhizotomy:

Not recommended. No studies. Considered experimental. See also Facet joint radiofrequency neurotomy.

Official Disability Guidelines (2008):

Facet joint radiofrequency neurotomy:

Under study. Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis (only 3 RCTs with one suggesting pain benefit without functional gains, potential benefit if used to reduce narcotics). Studies have not demonstrated improved function. Also called Facet rhizotomy, Radiofrequency medial branch neurotomy, or Radiofrequency ablation (RFA), this is a type of injection procedure in which a heat lesion is created on specific nerves to interrupt pain signals to the brain, with a medial branch neurotomy affecting the nerves carrying pain from the facet joints.

Current research: Multiple placebo-controlled trials have been completed on this topic, but these studies all had potential clinical methodologic flaws including the use of non-controlled diagnostic blocks and potential discrepancies in technique of lesioning from that which is currently recommended. (Hooten, 2005) (van Kleef, 1999) (Boswell, 2005) (Leclaire, 2001) (Van Kleef, 1999) (Gallagher, 1994) (van Wijk, 2005) A recent small RCT found that the percutaneous radiofrequency neurotomy treatment group showed statistically significant improvement not only in back and leg pain but also back and hip movement as well as the sacro-iliac joint test. There was significant improvement in quality of life variables, global perception of improvement, and generalized pain. But RF neurotomy was not a total treatment, and it provided relief for only one component of the patients' pain. (Nath, 2008) Observational Trials: One observational trial found 60% of patients received 90% relief at 12 months and 87% had 60% pain relief. The authors used confirmatory blocks with 80% pain relief. (Dreyfuss, 2000) Clinical audits have reported pain relief in almost 70% of patients at 6 months. (Gofeld, 2007)

Systematic reviews: When compiled into systematic reviews, the evidence has been found to be conflicting for a short-term effect (Niemisto-Cochrane, 2003) (Niemisto-Cochrane, 2006) and moderate to strong for a long-term effect when compared to a placebo. (Geurts, 2001) (Boswell, 2005) The latter systematic review failed to distinguish results between lumbar and cervical patients. A critical nonsystematic review by Slipman et al. reported "sparse evidence" to support use in the lumbar region (Slipman, 2003) and the ICSI did not feel the current scientific evidence allowed for a conclusion on the subject. (ICSI, 2005) Boswell et al have recently published a systematic review that included several new observational studies that came to the conclusion that the evidence for neurotomy was moderate (Level III) for long-term relief of cervical and lumbar facet joint pain. This conclusion was based on the standard techniques used in the United States. (Boswell2, 2007) Interventional strategies, such as prolotherapy, botulinum toxin injections, radiofrequency denervation, and intradiskal electrothermal therapy, are not supported by convincing, consistent evidence of benefit from randomized trials. (Chou, 2008)

Technique: There are several techniques. (Gofeld2, 2007) The North American technique uses tangential insertion of a curve-tipped cannula parallel to the nerves. There is a long learning curve and results vary among operators. The European technique relies on radiologic appearance. Potential technical flaws include inadequate exposure of the tip to the target nerve and generation of a lesion that is too small to ablate the nerve. There is also an Australian technique.

Factors associated with failed treatment: These include increased pain with hyperextension and axial rotation (facet loading), longer duration of pain and disability, significant opioid dependence, and history of back surgery.

Factors associated with success: Pain above the knee (upper leg or groin); paraspinal tenderness. (Cohen2, 2007)

Duration of pain relief: One retrospective analysis has determined that the mean duration of relief is approximately 10-12 months (range 4-19 months). Subsequent procedures may not be as successful (possibly secondary to technical failure or progression of spinal degeneration). (Schofferman, 2004) In a more recent study 68.4% of patients reported good to excellent pain relief at 6 months and showed consistent results with the above findings. (Gofeld, 2007)

Complications: Potential side effects include painful cutaneous dysesthesias, increased pain due to neuritis or neurogenic inflammation, and cutaneous hyperesthesia. Neuritis is the most frequent complication (5% incidence). (Boswell, 2005) (Boswell2, 2007) (Cohen, 2007) The clinician must be aware of the risk of developing a deafferentation centralized pain syndrome as a complication of this and other neuroablative procedures. This procedure is commonly used to provide a window of pain relief allowing for participation in active therapy. (Washington, 2005) (Manchikanti, 2003) See also Facet joint diagnostic blocks (injections); Facet joint pain, signs & symptoms; Facet joint medial branch blocks (therapeutic injections); Facet joint intra-articular injections (therapeutic blocks). Also see Neck Chapter and Pain Chapter.

Criteria for use of facet joint radiofrequency neurotomy:

- (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections).
- (2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at least 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period.
- (3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function.
- (4) No more than two joint levels are to be performed at one time.
- (5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.
- (6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy.

Criteria for the use of diagnostic blocks for facet "mediated" pain:

Clinical presentation should be consistent with facet joint pain, signs & symptoms.

1. One set of diagnostic medial branch blocks is required with a response of at least 70%. The pain response should be approximately 2 hours for Lidocaine.
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 NSAIDs) prior to the procedure for at least 4-6 weeks.
4. No more than 2 facet 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.
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 facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)
11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.