

SENT VIA EMAIL OR FAX ON
Aug/07/2009

Pure Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left L3/L4/L5 Neurotomy

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

REVIEW OUTCOME:

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

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 5/27/09 and 6/26/09

MD, Peer Review, 05/27/09

DO, 06/26/09

MD, MD, MD, MD, MD, MD, MD, Spine & Joint Hospital, 06/10/03, 09/15/03, 10/17/03, 10/21/03, 10/31/03, 11/20/03, 11/21/03, 11/26/03, 11/31/03, 12/18/03, 12/23/03, 01/09/04, 01/19/04, 02/26/04, 03/02/04, 06/25/04, 08/10/04, 09/16/04, 09/27/04, 09/28/04, 10/12/04, 10/13/04, 10/15/04, 10/18/04, 10/20/04, 10/22/04, 10/25/04, 11/02/04, 11/05/04, 11/08/04, 11/10/04, 11/11/04, 11/12/04, 11/23/04, 12/03/04, 12/14/04, 12/16/04, 01/07/05, 01/27/05, 01/28/05, 03/23/05, 03/25/05, 03/31/05, 05/27/05, 06/10/05, 08/30/05, 09/27/05, 09/08/05, 10/18/05, 10/27/05, 11/07/05, 11/18/05, 12/12/05, 12/27/05, 01/03/06, 01/05/06, 01/13/06, 01/17/06, 01/24/06, 02/03/06, 02/14/06, 03/28/06, 04/14/06, 06/05/06, 07/31/06, 08/16/06, 08/18/06, 09/28/06, 11/20/06, 01/03/07, 01/24/07, 03/02/07, 03/28/07, 05/16/07, 08/31/07, 09/14/07, 11/29/07, 02/26/08, 07/29/08, 10/14/08, 10/27/08, 02/07/09, 04/10/09, Hospital, 07/15/03, 07/28/03, 09/14/03, Rehab, 09/04/03, 09/08/03, 09/09/03, 09/15/03, 09/19/03, 09/22/03, 09/24/03, 09/29/03,

10/02/03, 10/07/03, 10/27/04, 04/20/05, 04/28/05,
MD, 08/03/04, 06/14/05,
Medical, 01/27/05, 09/08/05
Medical Center 05/16/05, 05/17/05, 07/26/05, 08/16/06
05/31/05, 06/01/05, 06/02/05, 06/06/05, 06/07/05, 06/09/05
RN, 09/30/05
MD, 12/17/07
MD, 06/18/08

PATIENT CLINICAL HISTORY SUMMARY

This is a man who injured his back in xxxx. He subsequently had a 360 fusion in 2003 and some hardware removal and reexploration in 2004. A spinal cord stimulator controlled the left lower extremity pain in 2005. He had facet injections and SI injections in 2007. The back pain persisted and he is on hydrocodone. He had a facet medial branch blocks on 2/7/09 of the L3-5 levels and had 80-100% pain relief for two months. Dr. requests two level RF blockage for back pain relief.

The post surgical CT myelogram showed the postoperative changes.

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

Dr. is correct with the anatomical discussion in his appeal. The facet joints are innervated by the branches from the medial branches of the superior and inferior nerves. Hence, the three requested nerve injections would cover the two adjacent facet joints. The prior successful facet joints confirm, within the limits of false positive studies, the presence of the facet joint pain generator. The RF rhizotomy is approved on a case-by-case basis as it is considered "under study" by the ODG. The patient meets the ODG criteria for the first RF neurectomy

Facet joint pain, signs & symptoms

Recommend diagnostic criteria below. Diagnostic blocks are required as there are no findings on history, physical or imaging studies that consistently aid in making this diagnosis. Controlled comparative blocks have been suggested due to the **high false-positive rates** (17% to 47% in the lumbar spine), but the use of this technique has not been shown to be cost-effective or to prevent a false-positive response to a facet neurotomy.

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....

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 $\geq 50\%$ 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.

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

ACOEM-AMERICA 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

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)