



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

DATE OF REVIEW: 6-18-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left radiofrequency ablation and 5 sessions of physical therapy

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

American Boards of Physical Medicine and Rehabilitation and Pain Management

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 12-13-05 MRI of the lumbar spine.
- MD., office visits on 1-8-09 through 5-4-09 (3 visits).
- 1-29-09 EMG/NCS.
- 6-8-09 MD., performed a Peer Review

PATIENT CLINICAL HISTORY [SUMMARY]:

An MRI of the lumbar spine dated 12-13-05 shows early degenerative disc space changes at L4-L5 congenitally shortened pedicles with mild bilateral neuroforaminal stenosis. Minimal facet degenerative disc.

Office visit with MD., on 1-18-09 notes the claimant was doing fine after last procedure done on 3-30-06. The claimant was pain free. The claimant reported the pain started about 2 months ago. The claimant complains of lower back pain radiating to the right leg with numbness and weakness to the right leg. The pain is affecting his ADL's. The claimant rates his pain as 8/10. The claimant had a lumbar transforaminal epidural steroid injection on 3-30-06. On exam, the claimant has normal sensory and motor exam. DTR are 2+, SLR is negative. There is tenderness over vertebral spinous process. There are muscle spasms, SI joint tenderness and PSIS tenderness. The claimant has range of motion restricted in all directions. The claimant has tenderness in bilateral in paravertebral areas and facet joint area. The evaluator recommended a medial branch block.

On 1-29-09, an EMG/NCS shows mild to moderate sensory-motor peripheral neuropathy.

Follow-up with Dr. on 3-3-09 notes the claimant reported that the procedure done on 2-25-09 helped relieve his low back pain. He only takes his medications as needed for pain. The claimant reports his level is 2/10. His ADL's have improved. The evaluator recommended medial branch block on the left. The claimant is continued with his medications.

On 5-4-09, Dr. notes the claimant reported that patient states last procedure done on 3/3/09 (LMBB) helped relieve his pain. Patient states he has a discomfort to lower back area radiating to right leg when walking or standing for a long period of time. Pain: Is not affecting activities of daily living Pain Is characterized as burning Pain radiates to; right

lower extremity Pain is associated with: weakness Pain is aggravated by: walking Pain is relieved by; rest. Pain Level: 0/10 on VAS. Activities of daily living: improved. Sleep: improved. Work Status: Employed. On exam, the claimant has Exaggerated lumbar lordosis. Inspection exaggerated lordosis. Range of Motion moderately restricted in all the directions due to pain. Tenderness moderate, present, bilateral, paravertebral area, facet joint area, PSIS area, sacroiliac joint, infra-gluteal area, iliolumbar and sciatic notch area. Tenderness over vertebral spinous process. SI joint tenderness PSIS tenderness, present, bilaterally. The claimant was continued on Celebrex and Darvocet and the evaluator recommended RFA, bilateral lumbar spine.

On 6-8-09, MD., performed a Peer Review. He noted that the issue in dispute is bilateral RFA and 5 sessions of physical therapy. The evaluator noted that the request for reconsideration is not approved. The requested service exceeds the ODG level of care. There is no documentation of a specific nerve root distribution and the neurologic assessment of 1-8-08 was normal. The claimant has appeared to have undergone an adequate course of physical therapy earlier this year. The physician attempted to perform a Peer to Peer with Dr. However, he was not available.

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

Medical records reflect the claimant has had good medial branch block results. In the past, a radiofrequency ablation performed in 2006 provided over 2 years of pain relief. ODG-TWC state that approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function. Based on the medical records provided, left radiofrequency ablation and 5 sessions of physical therapy is established as medically reasonable and necessary.

ODG-TWC, last update 5-28-09 Occupational Disorders of the Lumbar spine – Facet 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) (Niemesto-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 $\geq 50\%$ 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- 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
- 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)