



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

**DATE OF REVIEW: 5-22-09**

**IRO CASE #:**

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

Bilateral Cluneal Radiofrequency Thermocoagulation

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

American Board of Anesthesiology and Pain Medicine

**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**

- 3-18-06 MRI of the lumbar spine.
- 5-4-07 Electrodiagnostic testing of the lower extremities performed by
- 9-12-07 CT scan post discogram of the lumbar spine.
- MD., office visits from 8-26-08 through 4-9-09 (5 visits).
- 3-24-09 bilateral cluneal nerve block.
- 4-15-09 notice of adverse determination.
- 4-28-09 an adverse determination after reconsideration.
- 4-19-09, Dr. MD., provided a letter.

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

3-18-06 MRI of the lumbar spine shows focal protrusion of the L5-S1 disc probably represents a small midline herniation, but mass effect to the dural sac is minimal.

Electrodiagnostic testing of the lower extremities performed by, MD., on 5-4-07 shows left L5 radiculopathy.

A CT scan post discogram dated 9-12-07 shows findings consistent with posterior annular tear and an associated central annular rupture at L5-S1. The L4-L5 disc appears intact without evidence for annular tear or rupture.

On 11-25-08, Dr. the claimant complains primarily of pain to the lower lumbar spine. The pain radiates to the right buttock. On exam, the claimant neurological exam was intact. The evaluator continued the claimant on her medications and to schedule follow-up on a p.r.n basis.

Follow up visit with, MD., dated 12-8-08 notes the claimant had a bilateral L3-S1 facet medial nerve block. The claimant had no change in her overall health status. The claimant rates her pain as 2/10, but she had been inactive for the past few days. The claimant complains at lumbar spondylarthritis. The location of her pain is primarily in the lower lumbar spine. It does not radiate. She characterizes it as constant, severe, throbbing, and burning. This occurred at work. She notes some pain relief with rest and narcotic pain medication. The pain worsens with sitting and standing. Medical history is significant for prior herniated disk and back surgery. Her medications include Celebrex, Kadian and Dilaudid. On exam, the claimant has normal gait. The claimant reported

60-70% improvement of pain since the L3-L4, L4-L5 and L5-S1 facet medial nerve block. However, a significant amount of pain has returned. The evaluator recommended bilateral L4-L5 and L5-S1 radiofrequency thermocoagulation.

On 3-24-09, the claimant was provided with a bilateral cluneal nerve block.

Follow-up with Dr. on 3-24-09 notes the claimant is seen for follow-up from bilateral L3-L4, L4-L5 and L5-S1 thermocoagulation. The claimant reports no change in her condition. Medications were reviewed and updated. The claimant rates her pain as 5/10 with medications. The claimant reports she is still having significant pain on the right side, but the left side feels okay. On exam, the claimant has pain over the left and right posterior superior iliac crest. The evaluator recommended a bilateral cluneal nerve block. Diagnosis provided bilateral cluneal neuralgia. The evaluator provided the claimant with the recommended injection.

Follow up with Dr. on 4-9-09 notes the claimant is seen after bilateral cluneal nerve blocks. The claimant reports a VAS pain of 3. The claimant reported that the cluneal block helped for a couple of weeks. The evaluator reported the claimant had 90% improvement post the bilateral cluneal blocks, but here has been significant return of pain. Medications were reviewed.

On 4-15-09, a notice of adverse determination reflects a Peer-to-Peer Review. The evaluator spoke with the physician advisor. She notes injured worker has received anesthetic block and received 2 weeks relief of pain. Injured worker is having pain over the hip and MD is requesting RFTC for long-term relief of pain. However, most recent note does not describe any hip pain. The injured worker has undergone RFTC from L3-S1, however continues to have low back pain and pain into the hip. The cluneal nerve innervates the skin and sensory fibers of the hip. Injured worker is obviously having multiple pain generators with continued low back pain. It is extremely doubtful that RFTC to the cluneal nerve would be of any significant clinical benefit. Request not medically necessary. Refer to clinical judgment.

On 4-28-09, an adverse determination after reconsideration was provided. The claimant is a female with a date of injury on xx-xx-xx. She presented with lumbar spondyloarthritis, neuralgia and bulging lumbar disc. The location of pain is primarily in the lower lumbar spine. Significant history includes a prior herniated disk and disk replacement surgery in 12/07. Based on the information provided, the request is considered not medically necessary. There is no high quality peer reviewed medical literature to support the use of cluneal nerve radiofrequency ablation for chronic low back or buttock pain related to a history of failed back surgery syndrome. ODG does not provide a recommendation regarding the procedure for this condition and there is a lack of quality peer reviewed evidence based medicine to support the effectiveness of the requested treatment modality. Because of these factors, the treatment would be considered experimental/investigational and not medically necessary.

On 4-19-09, Dr. MD., provided a letter regarding the denial for bilateral cluneal nerve RFTC. The evaluator reported he received the denial for bilateral cluneal nerve RFTC. The claimant underwent bilateral cluneal nerve blocks on March 24, 2009 and returned to the clinic on April 9, 2009. At that time, she reported 80-90% approximately two weeks before the pain returned. The next logical step is to perform radiofrequency thermocoagulation of the cluneal nerves.

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

I agree with the previous reviews that, based on the information provided, the request is considered not medically necessary. There is no high quality peer reviewed medical literature to support the use of cluneal nerve radiofrequency ablation for chronic low back or buttock pain related to a history of failed back surgery syndrome. ODG does not provide a recommendation regarding the procedure for this condition and there is a lack of quality peer reviewed evidence based medicine to support the effectiveness of the requested treatment modality. The patient has pain that appears more wide spread than the distribution of the cluneal nerves. The patient even had medial branch blocks prior to the cluneal nerve blocks that brought the pain down to a 2/10. Subsequent RFL of the medial branches did not decrease the pain. Because of these factors, the treatment would be considered experimental/investigational and not medically necessary.

ODG does not address this request.

ACOEM Guidelines Chapter 12 (Revised 2007) Pages 189-190 note that Radiofrequency neurotomy, neurotomy, and facet rhizotomy are not recommended for the treatment of any spinal condition.

**-RATIONALE FOR RECOMMENDATION**

Radiofrequency lesioning has been evaluated in quality studies, although quality studies of surgical neurotomy were not found. The highest quality studies are largely negative. (Leclaire 01, van Wijk 05) The next lower quality study is more favorable, but used unconventional statistical testing. (van Kleef 99) The lowest quality study had worrisome results in the placebo. (Gallagher 94) Available systematic reviews also discuss additional significant methodological concerns. (Hooten 05) These further limit the robustness of conclusions. As results are permanent, there should be good evidence of long-term benefit prior to recommending this procedure. Permanently denervated joints in the appendicular skeleton are called Charcot joints, and over long-term follow-up they do not do well. Such evidence is not currently available and is a major flaw. All studies suggested the need for further research.

The theoretical basis of cutting or ablating nerve fibers seems sound as procedures that eliminate the pathway to conduct sensations of pain should be effective for the treatment of chronic pain syndromes. Unfortunately, the history of cutting or otherwise ablating nerves to treat numerous pain conditions throughout the body is suboptimal, with a not infrequent increased risk for developing additional chronic pain problems (North 91) that were only widely recognized after long-term follow-up studies were reported. There have been many attempts at this type of procedure over several

decades. Unfortunately, perhaps due to pain fiber regeneration, alternate pathways for conduction, phantom pain, ongoing neurological stimulation, and/or conduction from the transected or ablated nerve fibers, no procedure to date has been shown to be effective for the treatment of pain that involves cutting or ablating nerve fibers. An interesting finding in two of these studies is the possibility that patients with higher degree of successful blocks, (e.g., >80%) as opposed to the 50% threshold that is more widely employed, have better outcomes. (van Kleef 99; Gallagher 94) However, as this has not been proven it cannot be adopted as guidance at this point.

It is noteworthy how few patients thought to be candidates for the procedure actually have successful blocks (43.5% (van Kleef 99); 54.3%. (van Wijk 05) This suggests that the number of patients who could be successfully treated with this therapy, especially if the supposition in the prior paragraph proves true and the procedure is proven effective, would likely be quite small.

Radiofrequency lesioning is invasive, has adverse effects, and is costly. Quality studies currently do not support this intervention. Additional quality research is needed in this area as outlined above, as it is currently an experimental procedure for purposes of treating acute, subacute, and chronic LBP, and radicular pain syndromes and/or discogenic LBP. There are currently limited possible uses for this procedure. There are no quality studies identified to support surgical neurotomy or rhizotomy.

**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)**