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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 08/17/2010

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 Pain Management (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

Bilateral lumbar facet rhizotomy at L4, L5 64622, 64623

REVIEW OUTCOME

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

Overturned (Disagree)

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 04-25-08 report of Medical Evaluation from Dr.
- o 05-01-08 Imaging report cervical MRI read by Dr.
- o 05-01-08 Imaging report lumbar MRI read by Dr.
- o 04-23-09 report of Medical Evaluation from Dr.
- o 04-23-09 Review of Medical History and Physical Exam from Dr.
- o 02-04-10 Initial Consultation from Dr.
- o 03-04-10 Follow-up Report from Dr.
- o 03-15-10 Draft of Current Note from Dr.
- o 03-18-10 Follow-up report from Dr.
- o 04-29-10 Follow-up report from Dr.
- o 05-07-10 Procedure report - facet medial branch blocks L4, L5 from Dr.
- o 05-26-10 Treatment Re-Assessment and Discharge from Dr., Ph'D
- o 05-27-10 Follow-up report from Dr.
- o 06-22-10 Work Conditioning (Post-op) FCE from., unsigned-
- o 06-30-10 Adverse Determination Letter from
- o 07-30-10 Reconsideration - Adverse Determination Letter from
- o 0x-03-10 Fax cover appeal from unsigned
- o 08-09-10 Request for IRO from the Claimant
- o 08-10-10 Confirmation of Receipt of Request for IRO from TDI
- o 08-10-10 Notice to P&S of Case Assignment from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews, the patient is a male who sustained an industrial injury to the neck, right knee and low back on xx/xx/xx associated with a motor vehicle accident. His truck hit a bump and he

lost control and crashed through a steel fence. When he got out he slipped and twisted his ankle and knee. He hurt his back reaching for the door. Treatment has included medications, individual psychotherapy sessions, two epidural injections, right knee surgery in January 2010 and bilateral lumbar facet medial branch block. He is not currently working, having been displaced from his job.

Cervical MRI was performed on May 1, 2008 and showed multilevel intervertebral disc degeneration and facet arthropathy in the cervical spine. Greater uncovertebral joint hypertrophy on the right at C3-4 and C5-6 noted. Mild posterior protrusions were seen with no mass effect on the spinal cord.

Lumbar MRI was performed on May 1, 2008 and given impression: 1. Intervertebral disc degeneration and moderate bulging to a greater degree laterally on the right with associated spondylosis at L4-5. Superimposed moderate posterocentral/left paracentral protrusion and facet with ligamentum flavum hypertrophy causes mild circumferential mass effect on the thecal sac, greater in the subarticular recesses at L4-5. 2. Mild bulging noted at L5-S1 and to a slight degree laterally on the left at L3-4.

The patient underwent an impairment evaluation on April 23, 2009. He reports neck pain of 4/10 and tightness. He complains of 8/10 low back pain that radiates to the left leg. He complains of right knee pain of 6/10. He has been recommended for work hardening and pain management. He has had PT and he has had 1 epidural injection. He underwent a FCE in December 2008, which showed a physical demand classification of light lifting, 25 pounds with restrictions. He is using an antidepressant, hydrocodone and Anorex (Leptoprin-dietary weight loss supplement). He is 6 feet and 300 pounds. Lumbar exam showed tenderness on the right. He has a normal neurologic exam. Diagnosis is lumbar strain, cervical strain and right knee strain. He is now at MMI and has improved since last examined. He has a WPI of 10%. He would benefit from a work hardening program. He will not be placed at full duty until he completes work hardening.

The patient's current provider examined him on February 4, 2010 for right knee and low back pain. He has had medications, PT and epidural injections for the low back. The pain is associated with weakness, numbness and tingling in the low back. He describes a throbbing pain of 8/10. He reports shortness of breath, constipation, fatigue and anxiety. He had right knee surgery about a month prior. He is using hydrocodone 7.5/500 but it makes him nauseous. He uses Cymbalta 60 mg once a day, Zanaflex 4 mg prn and Mobic 15 mg once a day with good relief. Straight leg raise is pain free to 90 degrees right and left. Motor strength, sensation and reflexes are normal. There are no Waddell signs. Assessment is chronic low back pain, lumbar facet syndrome, right knee derangement status post right knee arthroscopic surgery and probable right shoulder arthropathy. He declines interventional management. Ibuprofen 800 mg will replace hydrocodone.

On March 4, 2010 the patient is willing to try an injection. He has positive facet rocking maneuver. There is 4/5 motor deficit on the right lower extremity. Recommendation is for a diagnostic bilateral lumbar facet medial branch block at L4-5. If positive, radiofrequency ablation will be the next treatment.

The patient underwent a surgical consultation examination on March 15, 2010. He rates his back pain as 6/10. He recently had right knee surgery. He is obese and in moderate pain during the examination. He has 4+/5 motor power in all groups. Straight leg raise is negative. MRI scans shows diffuse cervical and lumbar degenerative changes. There are signs of symptoms magnification and functional overlay. He was advised that he is not surgical.

At reevaluation on March 18, 2010 the patient is waiting for approval for a medial branch block. He has a pain level of 7/10. On April 29, 2010 he is doing about the same.

According to the procedure report dated May 7, 2010 the patient underwent bilateral lumbar facet medial branch blocks at L4 and L5. The spinal needle was directed under fluoroscopic guidance to the medial branch of the left L4 facet joint...5 cc of 0.5% Marcaine was injected at this area on the left...L5 facet...the identical procedure was performed on the right side.

The patient was reassessed in psychology on May 26, 2010. He is being treated for Major Depressive Disorder, single episode, secondary to a work injury. He has financial difficulty. He has returned to PT and has completed 5 of 12 sessions. He had a second ESI on May 27, 2010. He is recommended to continue individual psychotherapy for an additional 6 sessions.

At reevaluation of May 27, 2010 the provider noted the patient is status post bilateral lumbar medial branch blocks which provided 80% relief for one day. He is overall doing better since last visit. He reports a good sleep pattern. He rates his low back pain as 3-5/10 and no numbness in the lower extremities. He is using Zanaflex 4 mg, Ibuprofen 800 mg. and Cymbalta 60 mg BID. Assessment is good results with interventional management and position confirmation of the lumbosacral facets as source of pain. Significant changes from the previous exam are as follows: 3/4 lumbar facet paraspinal tenderness with fair range of motion and negative sensory deficits. Due to failure of conservative care, PT, NSAIDS, muscle relaxants, and home exercise, it is medically necessary to perform a bilateral L-S facet rhizotomy L4 and L5 rhizotomy as a therapeutic modality. He should also continue his current medications and attend PT.

The patient underwent an assessment for work conditioning on June 22, 2010. His work requires a Medium PDL and he is currently at a Light Medium PDL. The patient was recommended to attend work conditioning.

Request for bilateral lumbar facet rhizotomy at L4, L5 was considered in review on June 30, 2010 with recommendation for non-certification. 17 pages of medical records were reviewed. The mechanism of injury is unknown. The patient is using Zanaflex, Cymbalta and ibuprofen. He has been provided bilateral lumbar facet medial branch block, level and laterality not stated, undated, no operative report, which provided 80% relief for 1 day. He has also had a right knee arthroscopy with anterior and posterior cruciate ligament augmentation, partial medial and lateral meniscectomy, complete synovectomy, abrasion arthroplasty medial femoral condyle, and removal of adhesion on January 21, 2010. He attended 12 PT visits and HEP without resolution his condition. Reason given for facet blocks: He has failed conservative care; as a therapeutic modality. The provider was not available for a peer discussion, however, an assistant discussed the case. The patient had noted improvement with the facet

blocks per the report of 05/27/10. However, the operative report of the previous medial branch block was not provided for review and there is no objective documentation regarding exhaustion of conservative care such as PT, medications and exercises. Per guidelines, this procedure is still under study.

Request for reconsideration bilateral lumbar facet rhizotomy at L4, L5 was considered in review on July 13, 2010 with recommendation for non-certification. 40 pages of records were reviewed. Mechanism of injury: Motor vehicle accident. Imaging reportedly shows multilevel degeneration and facet arthropathy of the cervical spine, and dessication with bulging and moderate displacement of the right L4 nerve root sleeve at L4-5, and facet arthropathy at L3-4 and L4-5. A peer discussion was attempted but not realized. The medical records mentioned ineffective treatments and failed to provide an objective documentation representing an exhaustion of these conservative treatments, particularly pharmacology and physical therapy. Furthermore, the operative report of the previous medial branch block documenting the accuracy of the procedure was not provided for review. Facet joint radiofrequency ablation is still under study.

Request was made for an IRO.

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

ODG: Criteria for use of facet joint radiofrequency neurotomy:

- (1) Treatment requires a diagnosis of facet joint pain using a medial branch blocks.
- (6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy

First level review denial rationale essentially states the operative report of the previous medial branch block was not provided.

The second level denial rationale notes two factors: 1. The operative report of the previous medial branch block documenting the accuracy of the procedure was not provided for review. 2. No documentation of exhaustion of conservative treatments, particularly pharmacology and physical therapy.

The operative report has been provided and summarized as above. The patient has been maintained on an NSAID, a muscle relaxant and an anti-depressant. He used hydrocodone but it gave him nausea. He has attended individual psychotherapy sessions, undergone two epidural injections and attended PT (in May 2010 he returned to PT). He has a normal neurologic examination, has facet hypertrophy per imaging and obtained good response with a medial branch block with pain reduction of 80%. He has been assessed for additional evidence based conservative care (work conditioning). Based upon ODG guidelines, the patient meets the criteria for facet rhizotomy.

Therefore, my recommendation is to disagree with the previous non-certification of the request for bilateral lumbar facet rhizotomy at L4, L5 64622, 64623.

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 KNOWLEDGBASE

___ 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

The Official Disability Guidelines 08-05-2010 Lumbar Chapter: 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.

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. 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. Clinical audits have reported pain relief in almost 70% of patients at 6 months.

Systematic reviews: When compiled into systematic reviews, the evidence has been found to be conflicting for a short-term effect and moderate to strong for a long-term effect when compared to a placebo. 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 and the ICSI did not feel the current scientific evidence allowed for a conclusion on the subject. 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. 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.

Technique: There are several techniques. 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.

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). 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.

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). 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.

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 = 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.