

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

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 12/10/2010

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

Radiofrequency nerve blocks lumbar L5, S1, S2, S3

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 10-14-10 Office Visit report from Dr.
- o 11-01-10 Fax sheet - request for RFNA DPR at L5 and lateral branches S1-3 from Dr.
- o 11-05-10 Adverse Determination review from MRI
- o 11-08-10 Adverse Determination Letter
- o 11-15-10 Fax sheet - appeal for RFA from Dr.
- o 11-15-10 Appeal for RFNA from Dr.
- o 11-17-10 Adverse Determination review - reconsideration from MRI
- o 11-17-10 Adverse Determination Letter
- o 11-23-10 Request for IRO from the Claimant
- o 11-23-10 Confirmation of Receipt of Request for IRO from TDI
- o 11-23-10 Notice to Assignment from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is female employee (age not stated) who sustained an industrial injury to the low back on xx/xx/xx. She is followed in pain management with a diagnosis of lumbosacral spondylosis without myelopathy. She is status post radiofrequency nerve ablation (RFNA) in December 2008 with reported relief of 80-90% for 24 months. The patient is overweight (5' 9" and 294 pounds). Her health history includes migraine headaches and anxiety disorder.

The patient was seen in pain management on October 14, 2010 for medication compliance. She continues to suffer right-sided

back pain that radiates down the right lower extremity. She has been walking for 6 weeks and complains of muscle cramps and spasms in the left lower extremity from the knee to the ankle. The prior RFA procedure gave good relief of 80-90% for over two years. She was able to decrease her pain meds during the first year and her activity was increased. Her current pain level is 3/10. Over the past 30 days her pain level has varied from 3-8/10. Overall she has more severe pain. Her pain medication is approximately 75% effective. She is using NSAIDS and a narcotic pain reliever. She is allergic to Morphine. Diagnosis is lumbosacral spondylosis without myelopathy. She will continue Norco and Zanaflex. Recommendation is for repeat RFNA right DPR L5 and lateral branch S1, S2, S3.

Request for Radiofrequency nerve blocks lumbar L5, S1, S2, S3 was considered in review on November 5, 2010 with recommendation for non-certification. Per the reviewer, additional clinical information was gained from a call to the provider. The patient suffers from right-sided low back pain that travels to the right leg. No physical findings are reported. She is apparently being treated with Norco and Zanaflex. She underwent a previous radiofrequency denervation in 12/08 that provided 80-90% pain relief or two years. Rationale for denial states the nerve levels proposed for radiofrequency ablation do not correspond to the innervation of any facet joints. The lowest facet joint, L5-S1 is innervated by the L4 and L5 medial branches. It would appear that the intent is to denervate the SI joint, which is innervated by the requested nerves. Conversation with the provider confirmed that this is the case. ODG does not recommend RFA of the SI joints as there is inadequate published evidence of its efficacy. It is, however, appreciated that the patient has responded well to this treatment.

Letter of appeal dated November 15, 2010 states the patient suffers from lumbosacral spondylosis without myelopathy. A RFNA was performed in December 2008 and she received 80-90% pain relief lasting for 24 months. We believe this procedure will be beneficial to the patient.

Request for reconsideration Radiofrequency nerve blocks lumbar L5, S1, S2, S3 was considered in review on November 17, 2010 with recommendation for non-certification. A conversation took place with a non-physician colleague. Per the provider, the request is for sacroiliac joint radiofrequency ablation not facet RF. The patient had the same procedure 2 years ago and achieved 80% relief. Guidelines state that sacroiliac joint radiofrequency ablation is not recommended. There was no change in the determination. The letter of appeal stated the patient suffered from lumbosacral spondylosis without myelopathy. Guidelines support this procedure at no more than two joint levels at any one time. The request is for four levels and does not meet guidelines. Also, there is no evidence of a formal plan of aftercare in the documentation submitted for review.

Request was made for an IRO.

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

ODG (Hip and Pelvis Chapter)- does not recommend RFA of the SI joints as there is inadequate published evidence of its efficacy.

First level denial rationale noted that the nerve levels proposed for radiofrequency ablation do not correspond to the innervation of any facet joints. The lowest facet joint, L5-S1 is innervated by the L4 and L5 medial branches. ODG does not recommend RFA of the SI joints as there is inadequate published evidence of its efficacy. It is, however, appreciated that the patient has responded well to this treatment.

Second level denial rationale noted, guidelines support this procedure at no more than two joint levels at any one time. The request is for four levels and does not meet guidelines. Also, there is no evidence of a formal plan of aftercare in the documentation submitted for review.

RFNA is supported for facet mediated pain following positive response to a diagnostic medial branch block in patient's with no radicular signs. Studies support this procedure with specific criteria for lumbar facet joint pain. She has a diagnosis of lumbosacral spondylosis without myelopathy. Her primary complaints are right-sided back pain that radiates down the right lower extremity and muscle cramps and spasms in the left lower extremity from the knee to the ankle. She is using Norco and Zanaflex. She has reportedly benefited with radiofrequency ablation to the lumbar and sacroiliac nerves at four joint levels for almost 24 months in the past and repeat procedures are requested. However, there are no clinical examination findings to substantiate facet-mediated pain or to further explore muscle cramping in the lower leg. The relief reported is not further clarified in regard to decreased medication use or activities and there is no report of a formal plan of additional evidence-based conservative care in addition to RF treatment. ODG (Hip and Pelvis Chapter)- does not recommend RFA of the SI joints as there is inadequate published evidence of its efficacy.

Therefore, based on ODG guidelines, my recommendation is to agree with the previous non-certification for repeat radiofrequency nerve blocks lumbar L5, S1, S2, S3.

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
- 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 11-12-201- Low Back Chapter - 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.

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.

Suggested indicators of pain related to facet joint pathology (acknowledging the contradictory findings in current research):

- (1) Tenderness to palpation in the paravertebral areas (over the facet region);
- (2) A normal sensory examination;
- (3) Absence of radicular findings, although pain may radiate below the knee;
- (4) Normal straight leg raising exam.

Indictors 2-4 may be present if there is evidence of hypertrophy encroaching on the neural foramen.

ODG 11-12-2010 Hip and Pelvis Chapter: Sacroiliac joint radiofrequency neurotomy

Not recommended. Multiple techniques are currently described: (1) a bipolar system using radiofrequency probes (Ferrante,

2001); (2) sensory stimulation-guided sacral lateral branch radiofrequency neurotomy (Yin, W 2003); (3) lateral branch blocks (nerve blocks of the L4-5 primary dorsal rami and S1-S3 lateral branches) (Cohen, 2005); & (4) pulsed radiofrequency denervation (PRFD) of the medial branch of L4, the posterior rami of L5 and lateral branches of S1 and S2. (Vallejo, 2006) This latter study applied the technique to patients with confirmatory block diagnosis of SI joint pain that did not have long-term relief from these diagnostic injections (22 patients). There was no explanation of why pulsed radiofrequency denervation was successful when other conservative treatment was not. A > 50% reduction in VAS score was found for 16 of these patients with a mean duration of relief of 20 ± 5.7 weeks. The use of all of these techniques has been questioned, in part, due to the fact that the innervation of the SI joint remains unclear. There is also controversy over the correct technique for radiofrequency denervation. A recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. (Hansen, 2007) See also Intra-articular steroid hip injection; & Sacroiliac joint blocks.

Recent research: A small RCT concluded that there was preliminary evidence that S1-S3 lateral branch radiofrequency denervation may provide intermediate-term pain relief and functional benefit in selected patients with suspected sacroiliac joint pain. One, 3, and 6 months after the procedure, 11 (79%), 9 (64%), and 8 (57%) radiofrequency-treated patients experienced pain relief of 50% or greater and significant functional improvement. In contrast, only 2 patients (14%) in the placebo group experienced significant improvement at their 1-month follow-up, and none experienced benefit 3 months after the procedure. However, one year after treatment, only 2 patients (14%) in the treatment group continued to demonstrate persistent pain relief. Larger studies are needed to confirm these results and to determine the optimal candidates and treatment parameters for this poorly understood disorder. (Cohen, 2008)