



MedHealth Review, Inc.

661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax 972-775-6056

Notice of Independent Review Decision

DATE OF REVIEW: 9/22/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of RFTC (radio frequency coagulation) at L4-S1.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been performing this type of service for more than 15 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of RFTC (radio frequency coagulation) at L4-S1.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Physicians and Insurance

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Physicians: Denial Letter – 8/3/10 & 8/30/10; WC Pre-Auth Request – 8/23/10; Physicians Letters of Medical Necessity – 11/5/08 to 7/27/10, Discharge Instruction Sheets – 8/22/08 to 7/27/10, Clinic Progress Notes – 8/22/08 to 7/21/09 to 7/27/10;, MD Operative Reports – 2/22/08 to 5/3/10; MD Clinic Note – 6/7/10; Radiofrequency Thermocoagulation note – 9/28/09 to 5/3/10; Procedure nurse assessment – 9/22/08 to 5/3/10; Patient Return Form 9/22/08 to 7/21/09 to 5/3/10; Operative Report 9/28/09; Procedure notes 9/22/08 to 9/28/09; medication scripts 10/3/08 to 7/21/09; Median Branch Block reports 5/11/09 to 6/8/09; Phone Message Log- 2/18/09; History and Physical form 8/22/08; New Patient Form- 8/22/08; and, RN Triage Phase I Note – 4/16/10.

Records reviewed from Travelers Insurance: WC Pre-Auth Request – 7/28/10; Physicians Discharge Instruction Sheet – 5/3/10, Procedure Note – 5/3/10; MD Compensability report – 6/17/09; MD Addendum letter – 6/3/09, MMI report – 5/6/09; DWC69 – 3/11/09 & 5/6/09; Various DWC73s; and report – 3/11/09.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a male who was injured on the job xx/xx/xx while working as a xx. He was driving a truck when the left front tire blew, causing the truck to roll over. He sustained injuries to several areas including the neck and lower back.

On August 22, 2008 the patient was seen at the xxx. On September 22, 2008 bilateral trapezius trigger point injections were given. In the clinic progress note October 10, 2008 diagnostic right and left lumbar medial branch blocks were proposed.

On 12/23/2008 he underwent left lumbar medial branch blocks with local anesthetic only at the L4-L5 level and the L5-S1 level. On September 28, 2009 Dr. and Dr. performed left medial branch blocks from L3-S1 including the accessory branch of S1, with good results. The patient subsequently underwent RFTC medial branch blocks on the left and reported obtaining 75 percent pain relief.

He obtained 75-80 percent relief with right medial branch blocks on 4/13/09 and on 6/08/09 and asked for RFTC on the right. On 11/18/09 a letter of medical necessity was submitted, requesting right RFTC. The patient previously underwent double diagnostic left-sided medial branch blocks and subsequent radiofrequency thermocoagulation for which he is now experiencing greater than 75% relief. He has also undergone double diagnostic blocks on the right side of his lumbar spine with approximately 70 to 75% relief at both series. They are now requesting a right-sided radiofrequency thermocoagulation for more permanent pain relief secondary to this gentleman's lumbar spondylosis without myelopathy.

On 05/03/10 the patient underwent right L3-S1 radiofrequency thermocoagulation. He was seen in a family medicine clinic 06/07/10 regarding back pain. On 07/27/10 a letter of medical necessity was submitted by Dr. and Dr., requesting “another round of radiofrequency thermocoagulation on the right to hopefully control the pain better. He continues to work and would like to continue to work”. On July 27, 2010 he reported a pain level of 5/10. Dr. and Dr. submitted a Letter of Medical Necessity requesting repeat RFTC on the right. “It is believed at this point in time that there was not enough thermocoagulation performed with the initial radiofrequency thermocoagulation and we feel that it is in the patient's best interest to have another round of radiofrequency thermocoagulation to improve and hopefully control his pain better”.

No reports of imaging studies were submitted. In the history and physical examination 08/22/08 Dr. noted that the MRI of the lumbar spine showed mild degenerative disc disease at L5-S1 with a small central disc herniation causing mild spinal canal stenosis.

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

According to the ODG Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 09/08/10): 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. The criteria for use of facet joint radiofrequency neurotomy include the provision that “repeat neurotomies” should not occur at an interval of less than 6 months from the first procedure and that 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. However, Dr. and Dr. in the letter of July 27, 2010 state that there was not enough thermocoagulation performed with the initial radiofrequency thermocoagulation and “we feel that it is in the patient's best interest to have another round of radiofrequency thermocoagulation to improve and hopefully control his pain better”.

The ODG guidelines do not address the possibility of “not enough thermocoagulation” as a reason to repeat the procedure. However, in his favor, the patient did obtain long-lasting relief from the previous RFTC procedure to the left side in 2009. He responded very well to the double diagnostic blocks on the right side on 4/13/09 and on 6/08/09 with approximately 70 to 75% relief in both series. It was reasonable to assume that a good response would result from the proposed RFTC procedures to the right side.

As cited in the ODG Guidelines Lumbar medial branch neurotomy is an effective means of reducing pain in patients carefully selected on the basis of controlled

diagnostic blocks. Some 60% of the patients obtained at least 90% relief of pain at 12 months, and 87% obtained at least 60% relief. (Dreyfuss P, Halbrook B, Pauza K, Joshi A, McLarty J, Bogduk N, Efficacy and validity of radiofrequency neurotomy for chronic lumbar zygapophysial joint pain, Spine 2000 May 15; 25(10):1270-7

According to the study by Gofeld M, Jitendra J, Faclier cited in the ODG Guidelines: Those [patients] with an appropriate response to comparative double diagnostic blocks underwent standardized radiofrequency denervation of the lumbar zygapophysial joints... Of the 174 patients with complete data, 55 (31.6%) experienced no benefit from the procedure. One hundred and nineteen patients (68.4%) had good (> 50%) to excellent (> 80%) pain relief lasting from 6 to 24 months.

In conclusion, the patient responded well to the RFTC on the left side. He obtained an appropriate response to double diagnostic blocks on the right side. According to the ODG guidelines pertaining to radiofrequency neurotomy, approval of treatment should be made on a case-by-case basis. In this particular case the patient meets the selection criteria for the procedure, with a good prognosis for a favorable response on the right side, as was the case on the left side last year.

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)** (Dreyfuss P, Halbrook B, Pauza K, Joshi A, McLarty J, Bogduk N, Efficacy and validity of radiofrequency neurotomy for chronic lumbar zygapophysial joint pain, Spine 2000 May 15; 25(10):1270-7)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**