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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 1/3/2011

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 doctor (Board Certified), 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 sacroiliac joint rhizotomy (64622,

64640, 77003) 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

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient is a male employee who sustained an industrial injury to the low back on xx/xx/xx when he fell off a ladder. His right leg twisted during the fall and he landed on the right side of his body. He is status post anterior interbody fusion L5-S1 on June 17, 2009 and has been followed for persisting low back pain worse on the right side with radiation down the right leg with associated numbness and tingling.

Lumbar MRI performed on March 4, 2008 was given impression: "1. L5-S1 central disc protrusion without significant spinal canal stenosis. 2. Minimal L2-3 through L4-5 posterior annular disc bulges. 3. Mild levoscoliosis." Findings also state, minimal L5-S1 disc degenerative disc disease is seen with minimal disc desiccation and minimal posterior disc space narrowing. There is a central 4 mm disc protrusion at L5-S1 with mild flattening of the anterior thecal sac, however so significant spinal canal or neural foraminal stenosis is identified.

EMG studies of October 7, 2008 reportedly showed bilateral S1 radiculopathy, right greater than left.

Lumbar discogram performed April 28, 2009 showed negative disc provocation of disc L3-4 and L4-5 and positive L5-S1 disc

provocation. Post discogram CT showed small annular tear at L3-4 and complete posterior annular tear with epidural spread at L5-S1.

Preoperative assessment was conducted on June 17, 2009. The patient is scheduled for ALIF L5-S1 (or artificial disc replacement) on this date. He has never spent a night in a hospital. He has an unremarkable health history. He is using Wellbutrin 150 mg in the morning and hydrocodone. He is an and a non-smoker. He is 5' 10" and 180 pounds. He is medically stable to undergo the proposed surgery.

The patient underwent maximal discectomy L5-S1 on June 17, 2009 with removal of the intervertebral disc side-side, front-back; decompression of the anterior and lateral epidural spaces and insertion of a Peek prosthetic device and Infuse BPM2.

At follow-up on December 22, 2009 the patient was still in the COPE program and was starting to feel better with a regimen of exercises. His pain is really over the SI joints where he is tender. He started Wellbutrin 5 days prior and is also using Flexeril, hydrocodone and ibuprofen.

An impairment evaluation was conducted on January 5, 2010. He has some bowel and bladder difficulties and erectile problems since the surgery. Left Achilles reflex is weaker than right. There is decreased sensation on the right lateral leg to light touch. Sitting root test is positive bilaterally for low back pain only. According to the AMA Guides Evaluation for impairment, he does fit some of the criteria for radiculopathy with EMG changes and reflex changes. He is assigned 19% WPI.

A second impairment evaluation was provided on January 7, 2010. He has low back pain that radiates into the right leg down into the foot. An epidural injection was not significantly helpful. Facet injection gave him 60-70% improvement for about 3 days. This was followed by a medial branch block for confirmation of facet mediated pain and it was not confirmatory. He underwent discogram in April 2009 which showed concordant low back pain and abnormal disc at L5-S1; the other levels were normal. He then underwent an ALIF at L5-S1 in June 2009 which relieved his leg pain and much of his back pain, however he has residual low back pain. He describes constant sharp pain with any movement and burning across his lower back. He has new issues since the surgery of weak urinary stream with voiding and ED. He is scheduled for a urinary evaluation in January 2010. He denies any lower extremity paresthesias, numbness, tingling or weakness. His leg pain has resolved. He is 5' 5" and 194 pounds. Examination shows normal neurological function and negative straight leg raise. Pending further assessment for his neurological problems, he is not MMI.

Provider note of February 18, 2010 notes the patient will reach statutory MMI on February 22, 2010. He is otherwise not at MMI as the urologist determined that he has voiding dysfunction with urinary retention and erectile dysfunction secondary to his back surgery. Additional workup with multiple tests are planned. He will be scheduled for statutory MMI and receive an impairment rating at that time.

Impairment rating evaluation of February 24, 2010 noted medial branch blocks prior to the patient's surgery were not helpful. He would like to continue the Wellbutrin for depression but does notice it causes some anxiety and anger issues. EMG of October 2008 showed an S1 radiculopathy. He has normal gait and normal neurological functions. Impression is low back pain, status post lumbar fusion with some residual leg pain and neurologic dysfunction probably related to his back pain during surgery. He is assigned WPI of 5% at that time.

At reevaluation on April 8, 2010 the patient had not gotten better with his back pain in the COPE program. He has some functional improvement but remains with pain of about 4/10 in the low back and there is some right leg pain. He has a normal neurologic exam and negative straight leg raise. Patrick maneuver is positive right and left for SI joint pain. Yeoman maneuver is positive bilaterally and Gaenslen maneuver is positive, right more than left. Recommendation is for diagnostic/therapeutic SI joint injections.

On May 18, 2010 the patient was provided bilateral sacroiliac joint blocks for a diagnosis of low back pain, lumbar disc disease and bilateral sacroiliac joint dysfunction in a patient with a history of L5-S1 fusion. Anesthesia was Xylocaine 1% with sodium bicarbonate and conscious sedation with 5 mg of Versed (benzodiazepine sedative). SI joint injection solution was Ominipaque 240, 4 ml of 0.5% preservation-free Marcaine (bupivacaine) plus 6 mg of betamethasone (Celestone - glucocorticoid steroid.)

On June 25, 2010 the patient was noted to be on Nexium for quite some time pursuant to gastritis which resulted from medications for his back injury. He has been using ibuprofen, Lodine, Flexeril and Norco for quite some time.

Reevaluation note dated August 26, 2010 indicates the patient had SI injections in May 2010. He did get relief during the anesthetic stage. He states his pain level went from 5/10 down to 1/10. He did not get anything from the corticosteroid but he did get relief during the anesthetic phase. Based on that, he is probably a candidate for rhizotomy. He continues to remain off work and is using Xanax, Wellbutrin and Nexium.

The patient was provided a new patient consultation on November 11, 2010 for consideration of bilateral sacroiliac joint rhizotomy. The patient was treated conservatively and then with a fusion surgery. Post op he had some ED which has resolved. He has done chronic pain management. He was weaned off hydrocodone and muscle relaxants. He uses an occasional Xanax and has been on Wellbutrin and Nexium. He takes some Lodine. In May he underwent bilateral SI joint injections with 80-90% pain relief during the anesthetic phase - he had no prolonged therapeutic response. He does not have significant lumbar radicular pain. His pain is localized. He points to the SI notches bilaterally and into his gluteus musculature. He describes pain of 4/10 that is aching, stabbing and burning in nature. He uses smokeless tobacco. He is 5' 10" and 195 pounds. Straight leg raise

is negative. Patrick maneuver worsens pain bilaterally. He has positive Fortin sign bilaterally and positive stork maneuvers. Hip ROM remains intact. Sensation, motor functions and reflexes are intact.

On November 11, 2010 the plan for SI joint rhizotomy was further described. An outcome of 50% pain relief would be considered a success. He could probably expect between 50-80% pain relief. Recommendation is to use the new Bayliss cooled radiofrequency machine and protocol for lesioning the nerves, which seems to give a more reliable outcome compared to traditional thermal rhizotomy. This is due the size of the lesions are larger. Recommendation is for a two-step process of one side each as patients are uncomfortable sitting for at least a week after each procedure.

Request for bilateral sacroiliac joint rhizotomy was considered in review on November 18, 2010 with recommendation for non-certification. According to the reviewer, the patient had SI joint injections on 5-18-10 under conscious sedation using marcaine and a steroid mixture. The patient allegedly got relief during the anesthetic phase but did not get any benefit with the steroid phase, which would seem unusual. There was no trial of branch blocks noted. ODG would support the use of medial branch blocks as a prelude to any rhizotomy procedure with strict attention to the amount of sedation etc. with the branch blocks (per ODG TWC Low Back). A peer discussion was attempted but not realized.

Request for reconsideration bilateral sacroiliac joint rhizotomy was considered in review on December 7, 2010 with recommendation for non-certification. According to the reviewer, the patient was seen on 11/11/10 with chief complaint of lumbosacral pain. He underwent bilateral SI injections with 80-90 percent relief during the anesthetic phase, but no prolonged therapeutic response. On examination he has positive findings of SI joint dysfunction with positive Patrick maneuver, positive Fortin finger sign, and positive Stork maneuver. Based on the documentation provided, objective findings and subjective complaints, the proposed bilateral sacroiliac joint rhizotomy is not recommended as medically necessary. ODG notes limited evidence for this procedure per the ASIPP. A peer discussion was attempted but not realized.

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.

Given the lack of a confirmatory medial branch block and the lack of support for SI joint RFA in the ODG, the requested RFA procedure cannot be recommended. It is also noted that the previously provided SIJ block performed on May 18, 2010 resulted in temporary benefit only during the anesthetic phase, however the patient received conscious sedation during the procedure which calls into question the validity of this result.

Therefore, my recommendation is to agree with the previous non-certification for bilateral sacroiliac joint rhizotomy (64622, 64640, 77003).

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
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

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 11-12-2010- 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. 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.

Factors associated with success: Pain above the knee (upper leg or groin); paraspinal

tenderness. 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.