

CASEREVIEW

505 N. Sam Houston Pkwy E., Suite 200
Houston, TX 77060

Phone: 832-260-0439

Fax: 832-448-9314

Notice of Independent Review Decision

DATE OF REVIEW: June 21, 2011 Amended June 27, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral Lumbar RFTC L4-5 & L5-S1 with monitored anesthesia-# 64622x2 #64623 x2, #77003, & #01991 or #01992.

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

This reviewer is a Board Certified Physical Medicine and Rehabilitation physician with 15 years of experience.

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

July 30, 2009: M.D. performed a Bilateral L4 and L5 transforaminal ESI. Diagnosis: L4-5 disc displacement with spinal stenosis.

August 19, 2009: M.D. evaluated the claimant. Claimant complains of right lower lumbar pain, right gluteal pain and right hip pain. The claimant had a negative steroid response with no improvement in symptoms to date. PE: Point tenderness noted in right lower lumbar. ROM is limited. SLR while seated was negative bilaterally.

August 25, 2009: M.D. performed a right L4-5 and L5-S1 facets with arthrograms and diagnostic injection of local anesthetic and steroid.

September 9, 2009: M.D. evaluated the claimant. Claimant had a positive steroid response with 90% relief of usual pain. Medication: Lyrica. No PE noted for the lumbar spine.

November 19, 2009: M.D. performed a right L3 and right L4 dorsal median branches and right L5 dorsal rami with diagnostic blockade.

September 23, 2010: MRI of Lumbar Spine was performed. Impression: L4-5 3mm of broad based disc protrusion with mild bilateral foraminal narrowing. Moderate canal stenosis is seen with facet hypertrophy. L5-S1 is endplate spur formation and associated disc protrusion lateralizing 3mm into the foramina with moderate bilateral foraminal narrowing. There is facet hypertrophy and slight narrowing of the canal.

November 11, 2010: M.D. evaluated the claimant. Injection were performed at the right L4-5 and right L5-S1 facets without immediate complications. The claimant has 0% relief. Medications: Ibuprofen 200mg. PE: Motor testing showed well developed and symmetrical musculature in the bilateral lower extremities. No evidence of any weakness L1-S1. No atrophy noted. SLR while seated was positive on the left.

January 10, 2011: M.D. evaluated the claimant. PE: Motor testing showed well developed and symmetrical musculature in the bilateral lower extremities. No evidence of any weakness L1-S1. No atrophy. SLR seated was positive on the left for low back pain.

May 11, 2011: M.D. evaluated the claimant. Sensory Exam: Pinprick sensation normal bilateral L1-S1. Motor Exam: No evidence of weakness.

May 17, 2011: D.O., performed a UR on the claimant. Rationale: The last block was 18 months ago and no documentation to verify its result.

May 19, 2011: M.D., performed a UR on the claimant. Rationale: There is no documentation that the medial branch nerve blocks provided a greater than 70% pain relief.

PATIENT CLINICAL HISTORY:

The claimant is XX years old is X'X" and XXXlbs.

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

The previous decisions are upheld. Per the ODG Low Back Chapter under Facet Joint Radio Frequency Neurotomy treatment requires successful medial branch blocks. The claimant did have successful medial branch blocks but it was nearly 2 years ago and only to the right L4-5 and L5-S1 Facets. More recent (8 months ago) intra-articular facet injections to right L4-5 and right L5-S1 were unsuccessful with 0% relief. And the claimant has not had more recent medial branch blocks and has not had facet procedures involving the left side.

Per the ODG

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 $\geq 50\%$ 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.

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)