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Notice of Independent Review Decision

DATE OF REVIEW: September 20, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Radiofrequency rhizotomy L4-L5

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

Certified, American Board of Orthopaedic Surgery

REVIEW OUTCOME

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a male who was attacked by bees on xx/xx/xxxx. He lost his footing and fell about 10 feet, landing directly on his right shoulder and entire right side of his body.

2006: Following the injury, the patient was seen at the emergency room (ER) where x-rays were obtained and he was treated with oral medications. Magnetic resonance imaging (MRI) of the left knee revealed low-grade medial collateral ligament (MCL) sprain and bipartite patella. MRI of the right shoulder revealed thinning of the supraspinatus tendon with articular surface fraying, intermediate signal articular surface tendinopathy of the subscapularis tendon and small subchondral cysts of the greater and lesser tuberosities.

D.C., noted complaints of pain in the neck, low back and right shoulder along with headaches. He diagnosed right shoulder/cervical spine/left knee/lumbar sprain/strain and referred the patient to an orthopedic surgeon.

On December 14, 2006, M.D., an orthopedic surgeon, performed right shoulder diagnostic arthroscopy with labral debridement, minimal debridement of the articular-sided partial rotator cuff tear and subacromial decompression and distal

clavicle resection. The patient underwent postoperative therapy.

2007: Dr. placed the patient at maximum medical improvement (MMI) in spite of his ongoing shoulder and arm pain.

MRI of the cervical spine revealed 2-mm disc bulges from C3-C4 to C6-C7 with slight effacement of the thecal sac at all four levels. Electromyography/nerve conduction velocity (EMG/NCV) study of the right upper extremity was unremarkable.

Dr. noted some subjective complaints of neck and lower back pain. He sent the patient for a second opinion and to a pain management physician.

In a diagnostic interview, the patient was diagnosed with pain disorder, anxiety, reactive depression and chronic pain condition. He underwent individual psychotherapy sessions.

M.D., an orthopedic surgeon, noted neck, right shoulder, back and knee pain. He obtained an MRI of the right shoulder which revealed full-thickness 5 x 6 mm tear of the supraspinatus at 11:00 position and 4-mm undersurface tear of the supraspinatus tendon at the 12:00 to 1:00 position. He recommended a repeat arthroscopy and epidural steroid injection (ESI) to the cervical and lumbar spine.

On May 16, 2007, M.D., performed a designated doctor evaluation (DDE) and recommended a trial of cortisone injections and a second opinion, taking into consideration not only the arthrogram findings, but the inconsistencies in his presentation. The patient was not able to lift anything with his right arm.

On May 24, 2007, Dr. performed diagnostic right shoulder subacromial decompression with debridement of partial rotator cuff tear and superolateral grade-1 tear separate glenohumeral compartment. The patient was started on therapy.

A lumbar MRI was obtained for pain in the region. It revealed mild distance fusion and a small focal central disc protrusion at L4-L5. Dr. noted ongoing pain in the lower back and recommended a lumbar ESI.

M.D., a pain management physician, performed cervical ESIs without any improvement. The patient complained of headaches and pain in the neck associated with numbness and tingling in the upper extremities.

2008 – 2010: A cervical discogram revealed grade II C3-C4 and grade III C4-C5, C5-C6 and C6-C7. Dr. recommended anterior cervical discectomy and fusion (ACDF) at C6-C7.

On March 6, 2008, M.D., performed a DDE and deferred assessment of MMI as the patient needed to undergo a neurosurgical evaluation involving his cervical spine.

In September 2008, M.D., psychiatrist/neurologist saw the patient for posttraumatic headaches, frequent lightheadedness, mild depression, and trouble falling and staying asleep. He placed the patient on Pristiq and Lidoderm 5% patches to be applied to the back.

On September 16, 2008, Dr. assessed maximum medical improvement (MMI) in regards to the shoulder, but stated the patient was not at MMI in regards to the cervical spine. He assigned whole person impairment (WPI) rating of 12%. He further opined that the official disability guidelines (ODG) were improperly applied and surgery was medically necessary. An ACDF was performed at C6-C7 on June 30, 2010, followed by postoperative PT.

In the interim, Dr. saw the patient for lumbar pain radiating down both legs with occasional tingling in the legs. Examination showed paresthesias extending to the lower extremities with straight leg raise (SLR) testing. X-rays of the lumbar spine showed bony alignment with no evidence of fracture or subluxation. Dr. assessed protrusion at L4-L5 with radiculitis and performed an epidural steroid injection (ESI) at L4-L5 on November 6, 2009. This was followed by post-injection therapy. Dr. stated that if the symptoms persisted, a lumbar discogram would be appropriate. But this was denied by the carrier.

2011: On July 25, 2011, the patient underwent a medial branch block (MBB) at the left L4-L5 facet. Dr. noted significant improvement after the injection. However, the patient still had back pain that he rated as 6/10. Exam revealed positive Kemp's sign and back pain with SLR test. Dr. planned an outpatient radiofrequency rhizotomy at left L4-L5.

On August 12, 2011, M.D. denied the request for outpatient radiofrequency rhizotomy with the following rationale: *"The records reflect previous diagnostic injections at the left L4-L5 and L5-S1 facet joints with significant relief on 07/25/11. It is unclear whether nonoperative care has been undertaken. It is unclear of what the imaging studies demonstrate and why there is discrepancy between the test levels (L4-5 and L5-S1) and the single level (L4-L5) being proposed on this request. Based upon this information, further injection rhizotomy is not indicated and appropriate."*

On August 24, 2011, M.D., denied the appeal for outpatient radiofrequency rhizotomy at left L4-L5. Rationale: *"This is a male who was injured on xx/xx/xxx, in an unspecified mechanism. The claimant has had issues with chronic cervical and chronic low back pain. He underwent lower levels of care including injection therapy and epidural steroid injection on November 6, 2009, at L4-L5 with subsequent medial branch block on July 25, 2011 at L4-S1 (50% improvement of subjective pain until the most recent physical examination of August 4, 2011). Physical examination of August 4, 2011, documented pain 6/10, positive Kemp's sign left with normal lower extremity motor strength, normal reflexes, intact sensation of the bilateral lower extremities, no documented facet tenderness noted. MRI of the lumbar spine of June 11, 2007, documented L4-L5 central disc protrusion without facet disease, central foraminal significant stenosis or nerve root impingement. The claimant has had no documented facet disease on imaging provided for review from June 11, 2007, however has had positive response to medial branch block at L4-S1. It is unclear why the request is for only L4-L5 and why there is a discrepancy between this and the prior levels that underwent medial branch block. Radiology reports do not document facet disease. The claimant has no evidence of a formal plan of additional evidence-based conservative care such as oral medications, activity modification, physical therapy, etc. This is not documented in the notes provided. The request does not meet the needed criteria. Back pain is 6/10 about 10 days following the*

medial branch block.”

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

IT IS UNCLEAR AS TO HOW THE DIAGNOSTIC BLOCKS WERE APPROVED IN THE FIRST PLACE—THE CLAIMANT HAD LOW BACK PAIN WITH RADICULAR SYMPTOMS INTO BOTH LEGS; THIS ALONE SHOULD HAVE DISMISSED THE REQUEST. MOREOVER, THERE IS A LACK OF DOCUMENTATION TO SUPPORT THE FACETS AS BEING THE SOURCE OF SYMPTOMS. SEE BELOW:

Criteria for the use of diagnostic blocks for facet “mediated” pain:

Clinical presentation should be consistent with [facet joint pain, signs & symptoms](#).

1. One set of diagnostic medial branch blocks is required with a response of $\geq 70\%$. The pain response should last at least 2 hours for Lidocaine.
2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.
3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).
5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.
6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.
7. Opioids should not be given as a “sedative” during the procedure.
8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.
9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.

10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. ([Resnick, 2005](#))

11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. ([Franklin, 2008](#))]

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.

ONCE THE BLOCKS HAD BEEN PERFORMED, HOWEVER, THE REQUEST FOR RHIZOTOMY DOES NOT APPEAR TO MEET ODG CRITERIA FOR MULTIPLE REASONS (LACK OF EVIDENCED OF FACET ARTHROSIS, LESS THAN 70% RESPONSE TO DIAGNOSTIC BLOCKS, LEVELS INCONSISTENT WITH THE BLOCKS, ETC.). THE RATIONALE FOR DENIAL IS CLEARLY DELINEATED BY THE REVIEWERS. ODG SUPPORTS THE DENIAL. SEE BELOW:

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:

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES