



Notice of Independent Review Decision

DATE OF REVIEW: 02/10/12

DATE OF AMENDMENT: 02/14/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left Radiofrequency Ablation L5-S1 CPT - 64622, 64623, 77003

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

Board Certified In Orthopedic Surgery

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.

Left Radiofrequency Ablation L5-S1 64622, 64623, 77003 – OVERTURNED

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Lumbar Spine MRI, MIR & Diagnostic Center, 11/18/99
- Lumbar Spine MRI, Imaging Specialists, 01/16/02

- Electrodiagnostic Studies, Neurodiagnostic Associates, 10/17/02
- BHI2, 09/26/08
- Orthopedic Report, M.D., 03/02/09, 08/25/09, 12/15/09, 04/13/10, 07/16/10, 10/19/10, 02/10/11, 05/03/11, 08/23/11, 09/09/11, 12/09/11, 01/03/12, 01/11/12
- Lumbar Discogram, MRI & Diagnostic, 07/24/09
- Post-Discogram CT of Lumbar Spine, MRI & Diagnostic, 07/24/09
- Operative Report, Dr., 12/09/11
- Denial Letters, 01/10/12, 01/20/12
- Procedure Orders, Dr., 01/06/12
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was injured on xx/xx/xx and continued with persistent back pain. A lumbar discogram was performed, which demonstrated concordant pain at L5-S1 with abnormal nucleogram, which correlated well with the MRI findings. He had been treated with an extensive course of non-operative treatment, which included physical therapy, back school, medications, epidural steroid injections (ESIs) and a home exercise program. A lumbar discectomy and fusion were recommended, which was denied at a CCH. A diagnostic medial branch block at the left L5 and S1 level was recommended and performed on 12/09/11. He had a 70% decrease in pain. As a result, a left-sided L5-S1 radio frequency ablation rhizotomy was requested.

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

The ODG indicates that facet joint radiofrequency neurotomy (radiofrequency ablation) is under study. It further states that consideration should be done on a case by case basis. Dr. documented the patient having a diagnostic medial branch block with 70% positive response. He has had no prior radiofrequency neurotomies. Therefore, based on criteria from ODG regarding medial branch blocks and facet joint radiofrequency neurotomy, this patient's records indicate he would qualify under ODG for the radiofrequency ablation procedure at L5-S1.

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](#))]

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, decreased medications 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:

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**