

MATUTECH, INC.

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Notice of Independent Review Decision

Date: June 18, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right cervical rhizotomy C5-C7 CPT 64633, 64634

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

The physician advisor is Fellowship Trained in Pain Management, and Board Certified in Anesthesiology with Certificate of added qualifications in Pain Medicine by the American Board of Anesthesiology. The physician advisor is duly licensed to practice medicine in the state of Texas, and has over 20 years of active and current practice in the specialty of pain management.

REVIEW OUTCOME:

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

Upheld (Agree)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Corvel:

- Office visits (11/05/04 – 05/03/12)
- Injections (05/23/08 – 03/22/12)
- Utilization reviews (05/03/12, 05/17/12)

Dr.:

- Office visits (11/05/04 – 05/03/12)
- Injections (11/09/06 – 03/22/12)
- Utilization reviews (05/03/12, 05/17/12)

TDI:

- Utilization reviews (05/03/12, 05/17/12)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is currently a female with a history of intermittent neck pain.

The claimant has received intermittent treatment from Dr. since November 5, 2004, consisting primarily of cervical radiofrequency rhizotomies and occipital nerve blocks. During that time, rhizotomies have been performed either at the C3 through the C7 levels, or the C3 through C5 levels subsequently followed by C5 through C7 levels. These rhizotomies have been performed variably on the right or left side. Additionally, occipital nerve blocks have been performed intermittently throughout that time period. There is no documentation that any of the radiofrequency rhizotomy procedures were preceded by a diagnostic medial branch block. Following each of the procedures performed, Dr., or his physician assistant or nurse practitioner, documented the claimant receiving 50, 60 or 70 per cent relief of pain from the procedures, however, throughout that time period, and despite the documentation of that degree of relief, the claimant has continued taking OxyContin 30 mg B.I.D., and varying amounts of hydrocodone 10 mg up to three times daily. Physical examinations during that time period documented non-specific cervical spine tenderness and decreased range of motion. The only imaging studies documented for this claimant included an MRI apparently done around the time of injury which demonstrated slight loss of C6-C7 disc height and a small central and right sided C5-C6 protrusion with no neurological compression. Electrodiagnostic studies at around the time of the alleged injury were also reported as "unremarkable".

When the claimant initially saw Dr. on November 5, 2004, she complained of diffuse pain throughout the occipital scalp, neck, upper back and shoulders with a pain level of 3-10/10. She was, at that time, taking OxyContin 20 mg daily, Norco 10 mg P.R.N., and Duragesic 50 mcg patch every three days. Physical examination documented non-specific decreased range of motion in all directions with non-specific lateral neck tenderness and tenderness over the occipital grooves. Neurological exam was entirely normal.

On October 12, 2006, Dr. performed left C3 through C7 cervical facet medial branch rhizotomy without having documented performance of a prior diagnostic medial branch block. On November 9, 2006, he followed that with a right C3 through C7 facet rhizotomy.

On April 16, 2008, claimant followed up with Dr.. Her pain level was said to be 7/10 and her OxyContin dose had been increased by 300% to 30 mg twice a day.

On May 23, 2008, Dr. repeated right C5 through C7 facet rhizotomies, again with no diagnostic medial branch block. On August 12, 2008, the claimant returned to Dr. 's office with a pain level of 6/10 now complaining of left sided pain. She was still taking OxyContin 30 mg twice a day. On October 24, 2008, Dr. performed left C5 through C7 facet rhizotomy again with no diagnostic medial branch block documented. Three weeks later, the claimant returned to Dr. reporting

“substantial relief” but still taking the same amount of OxyContin. She now complained of pain on the right side of her neck only above the previous rhizotomy sites. Dr. stated she would need right upper cervical rhizotomies, and that he “did not believe it will be likely to perform the procedure on the left as almost all of the pain is now on the right”.

Dr. performed right C3 through C5 cervical rhizotomy on January 6, 2009, again without any diagnostic medial branch block. On February 6, 2009, the claimant returned to Dr. now complaining of pain on the left side, which had not been present before he performed the right sided injection therefore on March 3, 2009, again without any diagnostic medial branch block Dr. performed left C3 through C7 facet rhizotomy. Ten weeks later, on May 13, 2009, the claimant returned to Dr. reporting “significant improvement” but now complaining of pain in the occipital region. She was still taking OxyContin 30 mg twice a day and her pain level was said to be 4/10. On June 12, 2009, Dr. performed occipital nerve blocks. The claimant returned for evaluation on August 14, 2009, still taking OxyContin 30 mg twice a day. On November 13, 2009, the claimant again returned to Dr. still taking OxyContin 30 mg twice a day.

Four months later, on March 3, 2010, the claimant returned to Dr. who reported pain level of 2/10. On June 16, 2010, approximately three months later, claimant complained of recurrent bilateral neck pain primarily “at the base of the neck”. She was still taking OxyContin 30 mg twice a day and hydrocodone. On July 21, 2010, the claimant again returned to Dr. with a pain level of 3-4/10 still taking OxyContin as before. On August 6, 2010, Dr. performed right C3 – C5 radiofrequency facet rhizotomies again with no diagnostic medial branch block documented. One month later on September 8, 2010, the claimant returned to Dr. still taking OxyContin 30 mg twice a day complaining of increased left shoulder pain. Pain level was said to be 6/10. Physical exam documented full cervical range of motion with flexion, extension and lateral rotation. No shoulder examination was performed. On October 29, 2010, despite the claimant’s complaint of LEFT shoulder pain and despite having undergone RIGHT cervical facet rhizotomy on August 6, 2010, Dr. repeated right C5 through C7 radiofrequency rhizotomies on the RIGHT side on October 29, 2010. Two weeks later on November 12, 2010, the claimant returned to Dr. reporting a “greater than 50% improvement” with her pain with a pain level still of 4/10 and still taking the same OxyContin 30 mg twice daily. She continued to have pain on the left occipital and neck region. Four weeks later on December 8, 2010, Dr. followed up with the claimant noting that she still continued to complain of LEFT scalp pain and again reiterating that she received “60-70% improvement” following the rhizotomy procedure she had previously performed. Pain level, however, remained at a 6/10 level, clearly contradictory of that pain improvement assessment.

On December 28, 2010, one of Dr. nurse practitioners wrote a letter in support of a request for repeat cervical facet rhizolysis. In that letter, the nurse practitioner stated the claimant had a history of “doing extremely well with this procedure”

rating her pain relief in the past “at greater than 75%”. This was also said to “allow her to reduce the amount of pain medication she takes and improve her overall level of function”. Again, these assertions are not borne out by any of the documentation provided by Dr. previously.

On January 28, 2011, Dr. repeated left C5 through C7 cervical facet rhizolysis, following up with the claimant three weeks later on February 16, 2011. The claimant again reported her usual “60% improvement” but continued to take OxyContin 30 mg twice daily and had a pain level decrease to only 3/10. On March 21, 2011, Dr. repeated left cervical facet rhizotomy at the C3 through C5 level, despite the claimant’s allegation of more than 60% relief. Three weeks later on April 13, 2011, the claimant again was seen by Dr., reporting her usual “60% improvement” still taking the same amount of OxyContin and still having the same 4/10 pain level. Three months later, on June 8, 2011, Dr. again followed up with the claimant. She was still taking OxyContin 30 mg twice daily. No pain level was documented and physical exam documented nothing more than non-specific tenderness and cervical decreased range of motion. Claimant was continued on OxyContin 30 mg twice daily. Two months later, on August 18, 2011, the claimant followed up with Dr. complaining of one to two weeks of “severe occipital neuralgia pain”. Pain level had significantly increased to 8/10 despite ongoing OxyContin as before. Physical exam documented bilateral suboccipital tenderness with cephalad pain radiation, which Dr. diagnosed as a flare up of occipital neuralgia. On August 31, 2011, the claimant returned to Dr. still complaining of the same pain at the base of the head radiating to the scalp, although her pain level had decreased to 6/10. She was now taking OxyContin 30 mg three times a day as well as hydrocodone 10 mg. Physical exam documented non-specific cervical range of motion limitation and neck and occipital tenderness. Three months later on December 7, 2011, the claimant returned to Dr. still taking OxyContin 30 mg twice daily, now complaining of right neck and shoulder pain. Pain level was now only 4/10. Physical exam documented the same non-specific range of motion and tenderness of the neck. OxyContin was refilled as before.

On February 15, 2012, approximately two months later, Dr. followed up with the claimant for her increasing neck and bilateral occipital pain. She was still taking OxyContin 30 mg twice a day and hydrocodone 10 twice a day, now with Flexeril. Pain level was said to be 6/10. Physical exam documented decreased cervical range of motion and non-specific lateral neck tenderness. On March 22, 2012, Dr. repeated right C3 through C5 radiofrequency facet rhizolysis, again with no diagnostic medial branch block documented. One month later, the claimant returned to Dr. . She was still taking OxyContin and hydrocodone. He noted that he had performed right cervical rhizotomy approximately one month before with the same usual “60-70% pain relief”, but documented a pain level of 4/10, only approximately 30% better than the 6/10 documented before the procedure. Physical exam documented the same non-specific decrease in cervical range of motion and tenderness. Dr. refilled OxyContin 30 mg twice daily and requested right C5 through C7 radiofrequency facet rhizotomy. That request was appropriately reviewed by two separate physician advisors, both of whom

recommended non authorization of the request. In support of reconsideration of the request, Dr. 's nurse practitioner wrote a letter on May 3, 2012, in which she stated the claimant received "60-70% pain relief" following right C3-5 cervical rhizotomy on March 22, 2012, and "50% pain relief" when the C5-C7 levels were performed on the right on October 29, 2010. The second physician advisor, on May 16, 2012, noted the absence of documentation of any recent medial branch blocks to justify repeating the radiofrequency rhizolysis. No other records have been provided for my review.

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

According to ODG treatment guidelines, radiofrequency facet rhizolysis are considered appropriate treatment only after diagnostic medial branch blocks confirm the efficacy of blocking the medial branch nerves for pain relief. Throughout the almost eight years that the claimant has been treated by Dr. with repeated radiofrequency facet rhizolysis, there is no documentation of the claimant ever having undergone such diagnostic medial branch blocks. Moreover, despite the allegations of 60-70% relief following virtually each and every one of the radiofrequency procedures performed by Dr. , the claimant has never reduced her OxyContin use nor demonstrated any objective evidence of functional improvement such as return to work. The claimant is not doing any home exercise according to the entirety of the records provided for review. Therefore, given the clear evidence over the last seven plus years of repeated cervical radiofrequency rhizolysis procedures, the continuing unchanged and even increased intake of OxyContin, and the lack of any documentation of diagnostic medial branch blocks performed to justify the procedure according to ODG guidelines, the request of repeating radiofrequency facet rhizotomy is not medically reasonable or necessary, nor is it supported by ODG treatment guidelines. Specifically, the request for right cervical rhizotomy C5-C7 (CPT 64633, 64634) is not medically reasonable or necessary, nor supported by ODG treatment guidelines. In fact, according to ODG treatment guidelines, none of the radiofrequency cervical rhizotomies performed by Dr. over the last seven plus years met ODG treatment guidelines. Additionally, none of the repeat radiofrequency rhizotomy procedures performed by Dr. met ODG treatment guidelines or medical reason and necessity based on the unchanged use of OxyContin despite alleged 60-70% relief and lack of any objective evidence of functional improvement or significant decrease in pain levels despite any and all of those procedures. The recommendations of the previous physician advisors for non-authorization of this procedure, therefore, are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES