

CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: May 31, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral Lumbar Facet Radio Frequency @ L4/5, L5/S1, Fluoroscopy under Anesthesia, left side first then two wks later the right side

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

This physician is a Board Certified Physical Medicine and Rehabilitation physician with over 16 years of experience.

REVIEW OUTCOME:

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

Overturned (Disagree)

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:

04/22/11: MRI Lumbar Spine interpreted by MD

11/30/11: Evaluation by PA-C for MD with Spine Institute, LLC
12/23/11: Consultation by PA-C for MD with Interventional Pain Management
01/23/12: Procedure Note by MD
01/30/12: Established Patient Encounter by MD with Interventional Pain Management
02/29/12: Established Patient Encounter by PA-C for MD with Interventional Pain Management
04/11/12: Established Patient Encounter by MD with Interventional Pain Management
04/27/12: UR performed by MD
05/02/12: UR performed by MD
05/09/12: Established Patient Encounter by MD with Interventional Pain Management

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx while working for. The claimant was stacking chips on a shelf and developed a low back pain and leg pain. He was treated conservatively, which he failed to respond to and then underwent a left L4-5 discectomy by Dr. in 1994.

On April 22, 2011, MRI Lumbar Spine, Impression: 1. Lumbar spondylosis, moderate. 2. Bilateral neural foraminal narrowing is seen at multilevel levels of the lumbar spine as described above. 3. Findings consistent with a small-moderate sized herniated intervertebral disc are identified in the anterior aspect of the canal with minimal lateralization towards the left side of the L1-L2 level. 4. Slight bulging at the L2-L3 disc is seen in the anterior aspect of the canal. 5. Degenerative changes are identified at multiple discs of the lumbar spine involving predominantly the L4-L5 and L5-S1 levels.

On November 30, 2011, the claimant was evaluated by PA-C for MD. It was reported that he was seen at the last visit because of worsening of symptoms during the past several years. The current symptoms included worsening of low back pain, radiating pain down the lower extremities and the symptoms were made worse with sitting, activities, and walking. It was reported that the claimant underwent several injections (possible ESI) by Dr. without any significant relief. He also was evaluated by Dr. who recommended L3 to S1 fusion. An EMG/NCV was also completed, but Dr. did not have the report. At the prior visit, facet injections or SI joint injections were recommended by denied. Physical Exam: He was walking with a slight limping gait. He had slight loss of his lordotic alignment. He had tenderness to palpation along the paraspinal areas on both sides. He also had tenderness to palpation along the left SI joint area and tenderness to palpation along the facet joints at level of L3-L4, L4-L5 on both sides. He had negative straight leg raising test on both sides. ROM was limited due to those symptoms. He had grade 5 motor strength and sensory was intact. Knee jerk and ankle jerk were grade 2 and symmetric. X-rays of the lumbar spine showed

significant intravertebral height loss at level L3-L4 and L4-L5. There was evidence of retrolisthesis at level L3-L4 about 3mm. There was slight narrowing disc space height at level L5-S1. EMG/NCV done at Dr. office on 08/30/11 showed no evidence of acute or chronic radiculopathy or evidence of polyneuropathy. Diagnosis: 1. Lumbar disc disruption with desiccation from L2 down to S1. 2. Status post L4-L5 laminectomy and discectomy. 3. Postlaminectomy syndrome. 4. Possible SI joint disorders. Plan: Recommended bilateral facet injections at L4-5 and L5-S1.

On January 23, 2012, the claimant underwent Facet Lumbar L4-L5 and L5-S1 bilateral injections and arthrogram with fluoroscopy performed by MD.

On January 30, 2012, the claimant was re-evaluated by MD in follow-up on the medial branch block received days prior. It was noted that Norco was not providing relief. On physical examination there was gluteal tenderness, greater trochanteric tenderness, paravertebral muscle spasm, SI joint tenderness, and tenderness in the midline. ROM was decreased and there was diminished strength and tone due to pain. There was stiffness and tenderness at midline and bilateral facet joint levels from L3 through S1 levels. Motor strength, sensory and reflexes were intact. The claimant was prescribed Norco 10/325 and Restoril 15 mg. Lumbar RF Facet 1st level and Lumbar RF facet Addtl Level was ordered. Dr. did state that the claimant had an excellent short-lived response to the previous lumbar facet blocks. He stated that the positive response to the local anesthetic indicated that the Facet Joints were indeed pain generators, but there was no long-term therapeutic effect from the cortico-steroid, therefore the medical necessity for therapeutic Radio-frequency lesioning procedure was indicated.

On April 11, 2012, the claimant was re-evaluated by MD for lower back pain with a pain level of 9/10. On physical exam there was gluteal tenderness, greater trochanteric tenderness, paravertebral muscle spasm, SI joint tenderness, and tenderness in the midline. ROM was decrease and diminished strength and tone due to pain. Motor strength was 5/5 in all lower extremity musculature. Sensation was intact to light touch and pinprick. Reflexes were 2/4 in the patellar and Achilles tendon. Diagnosis: Lumbago, Lumbar disc herniation, Lumbar discogenic pain. The claimant was prescribed Diclofenac Sodium. Norco and Restoril were to be stopped on 05/11/12. It was reported that current medication provided adequate relief and the claimant was functional and active with the current pain medication regimen. It was also reported they would obtain approval from workers compensation for Radio Frequency.

On April 27, 2012, MD performed a UR on the claimant. Rationale for Denial: In this claimant, there was a reported positive Kemp's test on physical exam. There was no neurologic exam provided. There was mention there was a medial branch block performed with transient benefit. The duration and percentage of relief was not provided. There were no imaging studies provided or any other clinical information provided. Based on the lack of information provided, medical necessity could not be established.

On May 2, 2012,, MD performed a UR on the claimant. Rationale for Denial: ODG Guidelines for lumbar facet radiofrequency have not been met. ODG allows for lumbar facet radiofrequency if a diagnostic medial branch blocks obtains a response of 70% pain relief response for last at least 2 hours for Lidocaine. Review of available medical records do not document that the diagnostic medial branch blocks obtained a response of 70% pain relief response for last at least 2 hours. Also, supplied medical records do not document clinical rationale for the anesthesia.

On May 9, 2012, the claimant was re-evaluated by MD. It was reported that the claimant's pain level was 9/10 and the prior medial branch blocks gave him 70% relief. Dr. continued to recommend RFTC and continued him on current medications (diclofenac sodium 75 mg, Norco 10/325, and Restoril 15 mg.)

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

Decision to deny Bilateral Lumbar Facet Radio Frequency @ L4/5, L5/S1, Fluoroscopy under Anesthesia, left side first then two wks later the right side, is overturned/disagreed with. Per ODG Low Back Chapter, claimant received 70% pain relief from medial branch block-criteria for "successful" block as diagnostic of pain generator as facet joints was met. The request for Bilateral Lumbar Facet Radio Frequency @ L4/5, L5/S1, Fluoroscopy under Anesthesia, left side first then two wks later the right side meets ODG criteria and is found to be medically necessary.

Per 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, 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:

- 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**
- 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)**