CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: April 23, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Radiofrequency Ablation @ L4, L5, S1 using Fluoroscopy (77003 FLUOR GID & LOCLZI NDL/CATH SPI DX/THER, 64635 OSTR NROLYTC AGNT PARVERTEB FCT SNG, 64636 DSTR NROLYTC AGNT PARVERTEB FCT ADD)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a Board Certified Orthopedic Surgeon with over 40 years of experience.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
08/31/12: Initial Evaluation Report by, DC with Healthcare Clinic
09/26/12: MRI Lumbar Spine without Contrast interpreted by, MD
11/08/12: Orthopedic Consult by MD with Orthopedics
01/07/13: LMBB Operative Report by MD
01/07/13: Post Injection Note by MD

01/17/13: Orthopedic Report by MD
01/30/13: UR performed by MD
02/12/13: Orthopedic Report by MD
03/18/13: UR performed by MD

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a old male who was injured on xx/xx/xx while working for xx as a xx. He was picking up a full trashcan to dump in the dumpster and while twisting felt immediate pain in his lower back. According to the records, the claimant initially underwent physical therapy, but no therapy notes were provided to determine duration and efficacy. It was also noted he was treated with oral anit-inflammatories.

On xx/xx/xx, the claimant was evaluated by DC who on physical examination reported palpable tenderness, tightness, and myospasm noted over the lumbar bilateral paraspinal musculature. Motor was 5+/5 bilaterally, reflexes were 2+/2 bilaterally and there was decreased sensory noted in the bilateral S1 dermatome. Double leg raise was positive bilaterally, Kemp's was positive bilaterally, Lindner's was positive bilaterally and Straight leg raise was positive bilaterally. Lumbar x-rays were negative for recent fractures, dislocations, or osseous pathology. Decreased lumbar lordosis was noted due to myospasm. Diagnosis: 1. Lumbar IVD. 2. Lumbar radiculitis. 3. Myospasm. Plan: Begin passive care, refer to MD for medical management.

On September 26, 2012, MRI of the Lumbar Spine, Impression: 1. There is dehydration of the L4-L5 and L5-S1 discs. Remaining lumbar discs are adequately hydrated. Disc spaces and vertebral body heights are maintained at each level. The bone marrow is unremarkable. 2. At L1-L2, L2-L3, L3-L4 there is no disc bulge, herniation or neural foraminal narrowing. At L4-L5 posterior 2 mm disc protrusion/herniation with associated posterocentral annular tear best seen on T2-weighted sagittal images #6 & #7. No neural foraminal narrowing is present. At L5-S1 posterior 2 mm disc protrusion/herniation with associated posterocentral annular tear best seen on T2-weighted sagittal image #7 presses on the thecal sac and also contacts the anterior aspect of the S1 nerve root bilaterally as they began to emerge from the thecal sac on each side as seen on axial image #12. No neural foraminal narrowing is present. 3. No facet disease or spinal stenosis is present. No other findings are identified.

On November 8, 2012, the claimant was evaluated by MD for low back pain rated 4-10/10 with constant pain, discomfort with side-to-side movements, soreness, and stiffness. His complaints were reported more down his right lower lumbar area with no lower extremity symptoms. On examination he was clearly uncomfortable sitting in the chair and had difficulty getting out of the chair and onto the exam table due to pain in his lower back. There was severe tenderness on the right lower lumbar region, more so around L4-L5 and L5-S1 levels. Positive Kemp sign. There was decreased range of motion with flexion and extension and higher levels of pain with right and left lateral bending. Straight leg

raises were positive for back pain. His motor strength and sensation were intact in his lower extremities and his reflexes were 2+ in his patellae and Achilles. Gait was unremarkable. X-rays were obtained and revealed no bony abnormalities, no fractures. Impression: 1. Disk bulging of the lumbar spine. 2. Facet pain of the right L4, right L5 and right S1 regions. Plan: Dr. noted the claimant had exhausted physical therapy and oral anti-inflammatories with temporary relief and that physical exam revealed primarily axial mechanical back pain, therefore a medial branch block to his right L4, right L5, and right S1 regions were recommended to evaluate his mechanical back pain. If he did well following the injections, then radio frequency ablation to those levels was recommended.

On January 7, 2013, LMBB Operative Report, Post-Operative Diagnosis: Lumbar facet strain/syndrome. Procedures: 1. Lumbar medial branch block L4 facet nerve right. 2. Lumbar medial branch block L5 facet nerve right. 3. Lumbar medial branch block S1 facet nerve right. 4. Fluoroscopic localization needle, lumbar. (Note: during the procedure skin was anesthetized with 1% lidocaine and the injection was a mixture of Depomedrol and Marcaine 0.5%)

On January 7, 2013, a note following the injection by Dr. indicated 99% relief.

On January 17, 2013, the claimant was re-evaluated by MD who noted he had noticed significant improvement and rated his current pain as 3/10 with discomfort with side-to-side movements, soreness, and stiffness. On exam there was tenderness on his right lower lumbar region, more so around L4-L5 and L5-S1 level. He had positive Kemp sign with decreased range of motion with flexion and extension. Straight leg raises elicited back pain. Plan: The claimant had good relief following g a medial branch block and it was recommended to proceed with radio frequency ablation at those levels.

On January 30, 2013, , MD performed UR. Rationale for Denial: For the described medical situation, Official Disability Guidelines would not support this specific request to be one of medical necessity. This reference would not currently support this request to be one of medical necessity as specifics are not provided with respect to the amount of pain reduction was obtained from the recent attempt at treatment in the form of medial branch blocks. As such, presently, per criteria support by the above noted reference, medical necessity for this request is not currently established.

On February 12, 2013, Dr. disputed the original denial of the recommended radio frequency ablation to his lumbar spine. Dr. reported that the claimant's original pain levels were documented between 4/10 and 10/10 indicating his highest level of pain was 10/10. Following the diagnostic medial branch block on January 7, 2013, he reported 99% relief and on January 17, 2013 noted his pain level was between zero and 3/10.

On March 18, 2013, MD performed UR. Rationale for Denial: Additional records indicated following the previous medial branch block provided benefit. The

claimant underwent a therapeutic block and not a diagnostic block. Guidelines would not support proceeding with a radiofrequency ablation unless there was a positive diagnostic block utilizing only Marcaine for the injection and does not utilize corticosteroid. Guidelines indicate radiofrequency neurotomy would only be supported at two levels. The request is for three levels and a side was not specified. These procedures are not supported without a previous diagnostic block. Records do not reflect the claimant had any long lasting benefit from the therapeutic block. Therapeutic blocks should result in at least 70% pain relief initially followed by at least 50% pain relief for six weeks time which has not clearly been document ted. The request for reconsideration for radiofrequency ablation at L4-S1 using fluoroscopy is non-authorized.

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

The previous adverse determinations should be upheld. The diagnostic medial branch blocks should be carried out as described by ODG which recommends medial branch blocks at no more than two levels, no pre-injection pain medication or sedation, no therapeutic medication and no more than .5 cc of lidocaine at each nerve or facet so that other pain generators are not inadvertently blocked causing a misrepresentation of the pain relief. According to the records, the claimant underwent a therapeutic block with the use of a corticosteroid. ODG criteria then outlines that the blocks need to be confirmed post injection via VAS scales, medication usage and physical activity to support subjective reports of better pain control. ODG criteria for use of facet joint radiofrequency neurotomy indicates only two joint levels are to be performed at one time. ODG also indicates that there should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy, this was not provided in the records for review. Therefore, ODG criteria is not met and the request for Radiofrequency Ablation @ L4, L5, S1 using Fluoroscopy (77003 FLUOR GID & LOCLZI NDL/CATH SPI DX/THER, 64635 OSTR NROLYTC AGNT PARVERTEB FCT SNG, 64636 DSTR NROLYTC AGNT PARVERTEB FCT ADD) can not substantiated at this time.

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 ≥ 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.

Facet joint diagnostic blocks (injections)	Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. (Cohen, 2007) (Bogduk, 2000) (Cohen2, 2007) (Mancchukonda, 2007) (Dreyfuss, 2000) (Manchikanti2, 2003) (Datta, 2009) *Etiology of false positive blocks:* Placebo response (18-32%), use of sedation, liberal use of local anesthetic, and spread of injectate to other pain generators. The concomitant use of sedative during the block can also interfere with an accurate diagnosis. (Cohen, 2007) *MBB procedure*: The technique for medial branch blocks in the lumbar region requires a block of 2 medial branch nerves (MBN). The recommendation is the following: (1) L1-L2 (T12 and L1 MBN); (2) L2-L3 (L1 and L2 MBN); (3) L3-L4 (L2 and L3 MBN); (4) L4-L5 (L3 and L4 MBN); (5) L5-S1: the L4 and L5 MBN are blocked, and it is recommended that S1 nerve be blocked at the superior articular process. Blocking two joints such as L3-4 and L4-5 will require blocks of three nerves (L2, L3 and L4). Blocking L4-5 and L5-S1 will require blocks of L3, L4, L5 with the option of blocking S1. (Clemans, 2005) The volume of injectate for diagnostic medial branch blocks must be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate), as increased volume may anesthetize other potential areas of pain generation and confound the ability of the block to accurately diagnose facet pathology. Specifically, the concern is that the lateral and intermediate branches will be blocked; nerves that innervate the paraspinal muscles and fascia, ligaments, sacroiliac joints and skin. (Cohen, 2007) Intraarticular blocks also have limitations due to the fact that they can be technically challenging, and if the joint capsule ruptures, injectate may diffuse to the epidural space, intervertebral foramen, ligamentum flavum and paraspinal musculature. (Cohen, 2007) (Washington, 2005) (Manchikanti , 2003) (Dreyfuss, 2003) (BlueCross BlueShield, 2004) (Pneumaticos, 2006) (Boswell, 2007) (Boswell2, 2007) A recent meta-analysis concluded that there is insufficient evidence to evaluate validity or utility of diagnostic selective nerve root block, intra-articular facet joint block, medial branch block, or sacroiliac joint block as diagnostic procedures for low back pain with or without radiculopathy. (Chou2, 2009) This study suggests that proceeding to radiofrequency denervation without a diagnostic block is the most cost-effective treatment paradigm, but does not result in the best pain outcomes. (Cohen, 2010) See also Facet joint pain, signs & symptoms; Facet joint radiofrequency neurotomy; Facet joint medial branch blocks (therapeutic injections); & Facet joint intra-articular injections (therapeutic blocks). Also see Neck Chapter and Pain Chapter. **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 ≥ 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)]

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)**