

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: June 6, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient, lumbar, right radiofrequency thermocoagulation of the L4-5, L5-S1 facet joints, 64635, 64636, 72275, and 99144

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

This reviewer is Board Certified in Anesthesiology with over 6 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:

07/18/08: MRI Lumbar Spine interpreted
09/15/08: Evaluation
09/15/08: Flexion-Extension Lateral Lumbar Spine X-rays
09/26/08: NCS/EMG
11/25/08: Evaluation
01/05/09: Evaluation
10/08/09: Evaluation
10/27/09: Lumbar Myelogram and CT interpreted
11/23/09: Evaluation
12/17/09: Evaluation
02/08/10: Notice of Independent Review Decision regarding Inpatient; 1 night; lumbar laminectomy with fusion and instrumentation L4-5, L5-S1; and thoracic-lumbar-sacral orthosis back brace

03/30/10: MRI Lumbar Spine
02/08/11: Operative Report
06/14/12: UR regarding Lumbar RFTC left facets L4-S1
07/02/12: UR regarding Lumbar RFTC left facets L4-S1
10/17/12: UR regarding RFTC Right Lumbar facets L4 to S1
10/24/12: UR regarding RFTC Right Lumbar facets L4 to S1
03/13/13: Evaluation
03/18/13: UR performed
03/21/13: Appeal Letter
04/08/13: UR performed
05/14/13: Evaluation
05/17/13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx while stepping and climbing. He had a sudden onset of severe pain in the low back with radiating pain down both legs, particularly on the right with numbness and dysesthesias. He has undergone physical therapy, chiropractic care, and epidural steroid injections, facet injections, and individual psychotherapy sessions. Medication has included Norco, Skelaxin and Duexis.

On July 18, 2008, MRI of the Lumbar Spine, Impression: 1. Large central disc herniation at L5-S1, causing moderate to severe central spinal canal stenosis with mild bilateral neural foraminal narrowing. 2. The L4-L5 level shows a small central disc herniation, causing mild central spinal canal stenosis and bilateral neural foraminal narrowing.

On September 15, 2008, Flexion-Extension Lateral Lumbar X-rays, Impression: In flexion there is 6 degrees of flexion angulation between L1 and L5. In extension there is 24 degrees of extension angulation between L1 and L5. There is disc space narrowing at L4-5 and anterior osteophytes at L4-5. There is no subluxation seen on the flexion and extension views.

On September 26, 2008, NCS/EMG Impression: The patient demonstrates no evidence of entrapment neuropathy or radiculopathy in the bilateral lower extremities on today's exam. The patient's low back pain with radicular pain in the bilateral lower extremities does not appear to be secondary to a fixed peripheral neurologic lesion.

On October 27, 2009, Lumbar Myelogram and CT, Impression: L4-L5 disk space: Moderate narrowing of the disk space noted with mild irregularity of the vertebral body endplates and mild hypertrophic spurring anteriorly and posteriorly. Broad-based bulging of the disk is noted causing mild-to-moderate encroachment upon the anterior aspect of the dural sac and neural foramina. Facet joint laxity noted. Thickening of the ligamentum flavum noted posteriorly. These findings cause mild-to-moderate spinal canal stenosis and mild bilateral neural foraminal stenosis. The disk intensity material does extend along the posterior margin of the upper portion of the L5 vertebral body suggesting possibility of an associated

herniation of the disk. L5-S1 disk space: There is approximately 3 mm posterior subluxation of L5 on S1. Mild laxity of the facet joints noted. The disk and dural sac, however, are maintained.

On March 30, 2010, MRI Lumbar Spine, Impression: 1. Degenerative disk disease and facet disease, most notably at L4-L5 and L5-S1. 2. Heterogeneous diffuse T1 weighted signal within the marrow. This may be seen with anemia of chronic disease, correlate for history of such. Less likely consideration would include marrow infiltrative disorder such as leukemia.

On February 8, 2011, Operative Report Postoperative Diagnosis: Low back pain, right greater than left. Procedure: Radiofrequency thermocoagulation facets on the right side at L4-5 and L5-S1.

On June 14, 2012, in a UR performed regarding left RFTC lumbar facet L4 to S1, it was reported that the claimant had significant pain reduction of approximately 90% relief of the isolated lumbar spine from the previous thermocoagulation (right). There was no objective documentation of decreased use of pain medication or increased function following the procedure. Evaluation January 4, 2011 documented 90% overall pain reduction lasting several months after the last radiofrequency procedure, tenderness over the paraspinous region with absence of extremity symptoms of radiculopathy, deep tendon reflexes were hyperreflexic with no muscle wasting noted and significant range of motion deficits secondary to the severity of pain. However, it is further noted the patient had similar reductions in pain both back and leg with an April 2012 epidural steroid injection.

On October 17, 2012, in a UR performed regarding right RFTC lumbar facets L4 to S1 it was noted that previous left-sided MMB's followed by radiofrequency lesioning done on 7/26/12 provided significant relief of back pain, with decreased medication usage and increased functionality. MMB's on the right were recommended first prior to RFTC.

On March 13, 2013, the claimant was evaluated who reported the claimant presented after undergoing a radiofrequency coagulation of the facets on the left side but the right side was never improved and was performed back in July 2012. The left side had just now become symptomatic after receiving 100% pain relief for greater than 6 months. Current complaints were described as back pain that is aching, constant, sharp and stabbing. The symptoms are ongoing and moderately limits activities and can be alleviated by heat, ice, rest, position change and medication creams. Current medications included: Norco 10mg-325mg, Skelaxin 800 mg, and Duexis 800 mg. On physical examination there is chronic pain isolated to the lumbar spine. There was an absence of lower extremity radiculopathy and it is extremely painful and characteristic of facet pain. The left side continues to be the worse side. He did have 100% pain relief after the last radiofrequency thermocoagulation which was performed on the left in July 2012. No muscle wasting or new neurological deficits were noted. Overall, range of motion had improved dramatically and no weakness present. He had low back pain that remained isolated to the lumbar spine, the left side slightly worse than

the right. It extended into the buttock region but primarily involves the paraspinal area over the facet joints. Positive straight left raise left at 20 degrees and on the right at 30 degrees. Tenderness at the facet joints left worse than right. Deep tendon reflexes intact. Assessment: Lumbago (low back pain with left greater than right sided pain primarily over the facet joints). Plan: Proceed with a radiofrequency thermocoagulation of the facet joints at L4-5 and L5-S1 on the right side. He will continue more conservative modalities including physical therapy and medications.

On March 18, 2013, performed a UR. Rationale for Denial: The clinical information as to side of symptoms and signs needs to be clarified. Based on the current documentation, the requested services cannot be approved.

On April 8, 2013, performed a UR. Rationale for Denial: Based on the medical records presented to be reviewed, the claimant previously underwent a right sided radiofrequency procedure and never had any improvement in the right-sided symptoms. The most recent physical examination findings on March 13, 2013, document the claimant has symptoms worse on the left than on the right. The physical examination findings do not support proceeding with a right sided injection at this time, particularly since the previous injection did not result in any significant improvement.

On May 14, 2013, the claimant was evaluated who reported that the claimant responded to facet injections and subsequently the radiofrequency thermocoagulation which didn't allow 6-8 months of almost complete pain relief 70-80% overall pain reduction while we were able to proceed with the lesions. Currently his pain has worsened dramatically. On physical examination there were no new neurological deficits but he did have severe pain in the lumbar spine over the facet joints and had some significant muscle weakness, especially the lower extremities. Positive straight leg raise bilaterally at 30 degrees. There was exquisite tenderness over the facet joint over the paraspinal regions, left side worse. Plan: Proceed with a radiofrequency thermocoagulation of the facet joints at L4-5 and L5-S1 on the left side. Previously this procedure helped within 6 months at 80% overall pain reduction.

On May 17, 2013, UR performed. Rationale for Denial: The medical records provided do not denote the mechanism of injury. There is also mention of medial branch blocks and facet joint injections: however, those procedure notes are not included in the medical records presented to be reviewed. Reviewing the patient's entire claim shows he has had this kind of persistent pain. Innumerable requests have been received in the past for SI joint injections facet injection and the like. None of which have provided long term relief.

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

The previous adverse determinations are upheld. First and foremost, there continues to be quite a bit of confusion about the laterality of the requested procedure as well as laterality of the claimant's previous procedures and current

symptom complex. Though physical examination supports that the claimant's left sided symptoms are worse than the right, the request is for a right-sided RTFC at L4-L5 and L5-S1. There are no procedural notes reflecting diagnosis supported by medial branch block or facet injection. The physical examination, though not conclusive, supports proceeding with a left-sided RTFC, yet the request is for a right-sided procedure. Therefore, this request for Outpatient, lumbar, right radiofrequency thermocoagulation of the L4-5, L5-S1 facet joints, 64635, 64636, 72275, and 99144 is non-certified.

PER ODG:

<p>Facet joint radiofrequency neurotomy</p>	<p>Under study. Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis (only 3 RCTs with one suggesting pain benefit without functional gains, potential benefit if used to reduce narcotics). Studies have not demonstrated improved function. Also called Facet rhizotomy, Radiofrequency medial branch neurotomy, or Radiofrequency ablation (RFA), this is a type of injection procedure in which a heat lesion is created on specific nerves to interrupt pain signals to the brain, with a medial branch neurotomy affecting the nerves carrying pain from the facet joints.</p> <p><i>Current research:</i> Multiple placebo-controlled trials have been completed on this topic, but these studies all had potential clinical methodologic flaws including the use of non-controlled diagnostic blocks and potential discrepancies in technique of lesioning from that which is currently recommended. (Hooten, 2005) (van Kleef, 1999) (Boswell, 2005) (Leclaire, 2001) (Van Kleef, 1999) (Gallagher, 1994) (van Wijk, 2005) A recent small RCT found that the percutaneous radiofrequency neurotomy treatment group showed statistically significant improvement not only in back and leg pain but also back and hip movement as well as the sacro-iliac joint test. There was significant improvement in quality of life variables, global perception of improvement, and generalized pain. But RF neurotomy was not a total treatment, and it provided relief for only one component of the patients' pain. (Nath, 2008) <i>Observational Trials:</i> One observational trial found 60% of patients received 90% relief at 12 months and 87% had 60% pain relief. The authors used confirmatory blocks with 80% pain relief. (Dreyfuss, 2000) Clinical audits have reported pain relief in almost 70% of patients at 6 months. (Gofeld, 2007) <i>Systematic reviews:</i> When compiled into systematic reviews, the evidence has been found to be conflicting for a short-term effect (Niemisto-Cochrane, 2003) (Niemisto-Cochrane, 2006) and moderate to strong for a long-term effect when compared to a placebo. (Geurts, 2001) (Boswell, 2005) The latter systematic review failed to distinguish results between lumbar and cervical patients. A critical nonsystematic review by Slipman et al. reported "sparse evidence" to support use in the lumbar region (Slipman, 2003) and the ICSI did not feel the current scientific evidence allowed for a conclusion on the subject. (ICSI, 2005) Boswell et al have recently published a systematic review that included several new observational studies that came to the conclusion that the evidence for neurotomy was moderate (Level III) for long-term relief of cervical and lumbar facet joint pain. This conclusion was based on the standard techniques used in the United States. (Boswell2, 2007) Interventional strategies, such as prolotherapy, botulinum toxin injections, radiofrequency denervation, and intradiskal electrothermal therapy, are not supported by convincing, consistent evidence of benefit from randomized trials. (Chou, 2008)</p> <p><i>Technique:</i> There are several techniques. (Gofeld2, 2007) The North American technique uses tangential insertion of a curve-tipped cannula parallel to the nerves. There is a long learning curve and results vary among operators. The European technique relies on radiologic appearance. Potential technical flaws include inadequate exposure of the tip to the target nerve and generation of a lesion that is too small to ablate the nerve. There is also an Australian technique.</p>
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	<p><i>Factors associated with failed treatment:</i> These include increased pain with hyperextension and axial rotation (facet loading), longer duration of pain and disability, significant opioid dependence, and history of back surgery.</p> <p><i>Factors associated with success:</i> Pain above the knee (upper leg or groin); paraspinal tenderness. (Cohen2, 2007)</p> <p><i>Duration of pain relief:</i> One retrospective analysis has determined that the mean duration of relief is approximately 10-12 months (range 4-19 months). Subsequent procedures may not be as successful (possibly secondary to technical failure or progression of spinal degeneration). (Schofferman, 2004) In a more recent study 68.4% of patients reported good to excellent pain relief at 6 months and showed consistent results with the above findings. (Gofeld, 2007)</p> <p><i>Complications:</i> Potential side effects include painful cutaneous dysesthesias, increased pain due to neuritis or neurogenic inflammation, and cutaneous hyperesthesia. Neuritis is the most frequent complication (5% incidence). (Boswell, 2005) (Boswell2, 2007) (Cohen, 2007) The clinician must be aware of the risk of developing a deafferentation centralized pain syndrome as a complication of this and other neuroablative procedures. This procedure is commonly used to provide a window of pain relief allowing for participation in active therapy. (Washington, 2005) (Manchikanti , 2003) See also Facet joint diagnostic blocks (injections); Facet joint pain, signs & symptoms; Facet joint medial branch blocks (therapeutic injections); Facet joint intra-articular injections (therapeutic blocks). Also see Neck Chapter and Pain Chapter.</p> <p>Criteria for use of facet joint radiofrequency neurotomy:</p> <ol style="list-style-type: none">(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.
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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)**