



MedHealth Review, Inc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 7/10/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of lumbar radiofrequency ablation at Left L3, L4 and L5 using fluoroscopy.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of lumbar radiofrequency ablation at Left L3, L4 and L5 using fluoroscopy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed: 5/22/13 denial letter, 4/11/13 surgery reservation sheet, 4/19/12 to 5/8/13 orthopedic consult/reports, undated preauth request form, 3/26/13 report from SO, 3/5/13 muscle strength exam, 2/23/12 electrodiagnostic examination, 1/26/12 lumbar MRI report, 3/5/13 lumbar operative report, and 6/18/13 denial letter.

3/6/13 letter DD exam and DWC 69 11/27/12, 1/20/12 initial eval report, 1/22/13 to 3/5/13 muscle strength exams, 11/30/12 FCE report, 6/4/13 telephone conference report, 11/19/12 IRO report, 10/26/12 denial letter, 9/25/12 denial letter, 8/21/12 denial letter, and 8/22/12 denial letter.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The xx-year-old was injured when his back struck a table. He has been documented to have ongoing back pain. Exam findings have revealed limited motion and tenderness in the lumbar spine area. Straight leg raise was noted to result in back pain only as of 5-8-13. The neurologic exam was unremarkable. A prior 1-26-12 updated lumbar MRI revealed multiple areas of protrusions and/or herniations. Spinal stenosis was also noted. Electrical studies 2/23/12 were unremarkable for radiculopathy. Treatments have included medications along with therapy and a medial branch block at the L4-5 level. Immediate post block relief was noted to have persisted for weeks. Denial letters discussed the lack of recent and comprehensive detailed treatment trial and failure, lack of quantified response to medial branch block, lack of plan for additional evidence-based conservative care, lack of guideline-support for 3 levels and/or lack of consistent literature-associated efficacy.

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

There has been the lack of provision of detailed recent and comprehensive treatment trials and failures. There has not been a detailed quantification of the response to the medial branch block or detailed plan for additional evidence-based conservative care. There is a lack of guideline-support for 3 levels performed at the same setting. Finally, there is a lack of consistent literature-associated efficacy with the requested procedures. Therefore, medical necessity as not been fully established at present.

Reference: ODG Lumbar Spine: 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.

Current research: Multiple placebo-controlled trials have been completed on this topic, but these studies all had potential clinical methodological flaws including the use of non-controlled diagnostic blocks and potential discrepancies in technique of lesioning from that which is currently recommended. 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. Observational Trials: 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.

Systematic reviews: When compiled into systematic reviews, the evidence has been found to be conflicting for a short-term effect and moderate to strong for a long-term effect when compared to a placebo. 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 and the ICSI did not feel the current scientific evidence allowed for a conclusion on the subject. 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. 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.

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)