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Notice of Independent Review Decision

DATE: July 6, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Radiofrequency Ablation Bilateral L4-L5, L5-S1 (64635, 64636)

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

The reviewer is certified by the American Board of Orthopaedic Surgery with over 13 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:

11/19/08: Discogram Report
11/19/08: CT Lumbar Spine Post Discogram report
01/12/10, 05/11/10, 01/25/11, 09/27/11: Office Visits
02/21/11, 04/11/11, 06/29/11: Operative Reports
03/07/11, 05/05/11, 07/18/11, 08/15/11, 09/12/11, 10/03/11, 11/14/11, 01/05/12,
05/21/12, 11/26/12, 12/31/12, 05/20/13, 07/22/13, 10/21/13, 01/20/14: Office
Visits
03/22/12: Office Visit
04/02/14: UR
05/08/14: UR
05/14/14: Note

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his low back (mechanism of injury not provided) while working on xx/xx/xx.

11/19/08: Discogram report. Discogram at L2-L3, L3-L4, L4-L5, and L5-S1 produced no pain at L2-L3, mild concordant pain at L3-L4, severe concordant pain at L4-L5, and severe concordant pain at L5-S1.

11/09/08: CT Lumbar Spine Post Discogram report. IMPRESSION: A right posterolateral grade 1 fissure is present in the L2-L3 disc. A posterior and left lateral grade V fissure is present in the L3-L4 disc. A right posterolateral grade IV radial fissure is present in the L4-L5 disc. A grade IV circumferential fissure is present in the L5-S1 disc.

01/12/10: The claimant was evaluated who noted that he was doing very well and was back at work full time. He was still having some left-sided hip pain but nothing severe and it was primarily with weather change. It was noted that he was status post disc replacement with ProDisc at L4-L5 and L5-S1 on 01/12/09.

02/21/11: Operative Note. POSTOPERATIVE DIAGNOSIS: Low back pain. Lumbosacral spondylosis. History of L4-L5, L5-S1 ProDisc replacement. PROCEDURES: Left L4-L5, L5-S1 facet joint injections. Fluoroscopic guidance needle placement.

03/07/11: The claimant was evaluated who noted that he had 75-85% improvement after L4-L5 and L5-S1 injection performed on 02/21/11 but that the injection was wearing off.

04/11/11: Operative Note. POSTOPERATIVE DIAGNOSIS: Low back pain. Lumbosacral spondylosis. OPERATIONS PERFORMED: Left L4-L5 and L5-S1 facet medial branch block. Fluoroscopic guidance of needle placement.

05/05/11: The claimant was evaluated who noted that he had about 80% pain relief during the anesthetic phase after left-sided medial branch blocks performed on 04/11/11 but then he re-aggravated his back after mowing the lawn.

06/29/11: Operative Note. POSTOPERATIVE DIAGNOSIS: Low back pain. Lumbosacral spondylosis. OPERATIONS PERFORMED: Left L4-L5 and L5-S1 facet joint medial branch cooled radiofrequency rhizotomy. Fluoroscopic guidance for needle placement.

07/18/11: The claimant was evaluated who noted a decreased level of pain in his low back after lumbar facet rhizotomy performed on 06/29/11. He noted 60-70% improvement in pain.

07/22/13: The claimant was evaluated for complaints of back pain. It was noted that since his last visit, he was involved in a severe motorcycle crash on xx/xx/xx. His medications included Medrol (Pak), Percocet, and Zanaflex. On exam, his gait was balanced. Paravertebral muscles were tender bilaterally. Lumbar ROM was normal in all directions and non-painful. The spinous processes were nontender. SLR was normal bilaterally with no issues. He was given a refill of Zanaflex and Percocet and was to followup as needed.

10/21/13: The claimant was evaluated for back pain. He had had a left hip replacement and was to have a left knee replacement. One exam, paravertebral muscles were tender bilaterally. Lumbar ROM was normal in all directions and non-painful. Spinous processes were nontender. SLR was normal bilaterally with no issues. He was given refills of Zanaflex and Norco and was to followup as needed.

01/20/14: The claimant was evaluated for back pain. It was noted that he had been treated with medications and physical therapy as well as facet rhizotomies. He was wanting to get rhizotomies again. It was noted that he managed with home exercises. He was currently taking hydrocodone 2 tablets b.i.d. He rated his pain as 4/10 with medication and higher without medication. On exam, paravertebral muscles were tender bilaterally. Spinous processes were nontender. SLR was normal bilaterally with no issues. Bilateral muscle strength was 5/5. Lumbar forward flexion was unrestricted to the full range. Back extension was at restricted with extension and rotation. He was to continue the Zanaflex and Norco and bilateral L4-L5 and L5-S1 radiofrequency ablation was recommended.

04/02/14: UR. RATIONALE: The guidelines state radiofrequency neurotomy should not be repeated at an interval of less than six months than the first procedure, when there is documentation of at least 12 weeks of greater than or equal to 50% pain relief. The provided records indicate the claimant previously underwent radiofrequency neurotomy. However, documentation of efficacy and length of relief was not noted. There is no documentation of when the rhizotomy was performed. The medical records only documented history of previous disc replacement and previous joint injection. Based on these factors, the request for radiofrequency ablation, bilaterally at L4-L5, L5-S1 is not certified.

05/08/14: UR. RATIONALE: The previous non-certification on 04/02/14 was due to lack of documentation of at least 12 weeks of 50% or more pain relief. The previous non-certification is supported. Additional records were not provided for review. Radiofrequency neurotomy should not be repeated at intervals of less than six months when there is documentation of less than 12 weeks or greater than or equal to 50% pain relief. The claimant had prior radiofrequency ablation procedures without objective documentation of efficacy or length of relief noted. There was no documentation of the length of relief from the prior rhizotomies. The request for appeal is not certified.

05/14/14: A note notes that experienced greater than 50% relief for a period of a year and a half following his lumbar facet rhizotomy on 06/29/11.

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

The previous adverse decisions are upheld. The Official Disability Guidelines (ODG) supports facet joint radiofrequency neurotomy for the treatment of facet joint pain. Repeat neurotomy is recommended for the symptomatic patient who

has had at least 50% pain relief for a minimum of 12 weeks following the procedure. At the present time, it is unclear whether the L4-L5 and L5-S1 facet joints are the claimant's primary pain generators. The claimant did receive more than 50% pain relief for a period of 18 months following the June 2011. However, the claimant was involved in a significant motorcycle accident in xx/xxxx, which worsened his back pain. A lumbar CT discogram performed in November 2008 identified disc fissuring at L2-L3 and L3-L4. These levels could have been aggravated by the motorcycle accident. Adjacent disc degeneration could have occurred at these levels following the 2009 disc replacements. The record indicates full painless lumbar range of motion in July 2013 and October 2013, which is not consistent with facet disease. A new MRI is recommended to identify the claimant's primary source of back pain that requires treatment. As the ODG criteria have not been met, the request for Radiofrequency Ablation Bilateral L4-L5, L5-S1 (64635, 64636) is not medically necessary and is not recommended based on the records reviewed.

ODG:

<p>Facet joint radiofrequency neurotomy</p>	<p>Criteria for use of facet joint radiofrequency neurotomy:</p> <p>(1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections).</p> <p>(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.</p> <p>(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.</p> <p>(4) No more than two joint levels are to be performed at one time.</p> <p>(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.</p> <p>(6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy.</p>
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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)**