

Vanguard MedReview, Inc.

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April 14, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12/15/2014 & 03/23/2015 Ablation (Radio Frequency)

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

This reviewer is a Board Certified Anesthesiologist 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was moving when he fell and injured his low back.

10/03/2013: Lumbar Spine, Five views. **Impression:** Views of the lumbar spine demonstrate the vertebral body height to be preserved, Osteophyte formation is present on an anterolateral fashion throughout the lumbar spine. There is marked narrowing of the L4-5 and L5-S1 interspaces, representing degenerative disc disease. There is no evidence of spondylosis or listhesis. The spinous processes and sacroiliac joints appear normal.

11/07/2013: MRI Lumbar Spine. **Impression:** L1-2: No disc herniation canal or foraminal stenosis. L2-3: No disc herniation, canal or foraminal stenosis. Mild facet Arthropathy. L3-4 No disc herniation canal or foraminal stenosis. L4-5: Slight retrolisthesis of 4 on 5 Disc bulge Mild facet Arthropathy. Mild canal and foraminal stenosis. L5-S1: No disc herniation canal or foraminal stenosis.

10/23/2014: Operative Report. **Pre-Op Diagnosis:** 1. Lumbar Spondylosis 2. Intractable Back Pain **Indications:** The patient is currently suffering from

intractable back pain secondary to lumbar spondylosis. At this time his pain has been refractory to conservative medical management. Therefore, after a full explanation of the risks and benefits of the procedures were discussed in detail, an informed consent was obtained to undergo the listed procedures and placed in the chart. **Findings:** Pre-op vitals: BP-145/88 Temp-97.4 HR-103 RR-16 O2 Sat-97 Post-op vitals: BP-97/66 HR-85 RR-16 O2 Sat-98

12/19/2014: Office Visit. **HPI:** Since injury, patient has noted a progressive pain in the low back and left lower extremity. Due to the progressive pain, the patient has difficulty with ambulation and completing several ADL's. He was previously under the care of a physician who performed lumbar epidural steroid injections. The patient was pending a radiofrequency ablation but the procedure was not done. relocating. The patient is here for a follow up and is reporting increased pain to his lower back which is radiating to his left groin. He reports the previous epidural steroid injections provided him only minimal relief. He was previously programmed for radiofrequency ablation and is requesting we get authorization. Denies: recent fall, recent trauma, recent surgery. Lower back: Described miserable, sharp, burning, tender, unbearable. Onset and severity: insidious, severe. The radiation of the pain is to the left lower extremity. Neurology: Myalgia in lower back. Paresthesia None. Weakness none. **Pain Management:** The pain interferes with general activity, relationships, normal work, sleep, mood, enjoyment of life. The pain is aggravated by standing, sitting, lying down, physical activity. The pain is improved by cold, pain medications. The pain is associated with fatigue, insomnia, anxiety. Treatments in the past have been interventional pain procedures, physical therapy, Pain scale 8/10. The relief medication provides: 70%. Imaging studies that have been done X-ray, MRI. **Examination:** No tenderness to palpation in cervical spine, no paraspinal spasms, full cervical flexion, full cervical extension, Bilateral suppling sign negative, no tenderness to palpation in thoracic spine, no paraspinal spasms. DTRs 2+ throughout. Lower Back: no visible or palpable masses. Palpation: severe tenderness to deep palpation in lumbar spine and bilateral paraspinal musculature, left lumbar paraspinal spasms. ROM: Flexion to 30 degrees, extension limited secondary due to pain, normal rotation with pain on extremes of motion, lumbar facet loading is positive bilaterally. Straight left raising is positive bilaterally. Stability: normal. Strength: Pt able to heel and toe walk with pain. **Assessment:** 1. Lumbosacral spondylosis without myelopathy-721.3 (Primary) 2. Lumbago-724.2 3. Chronic pain syndrome-338.4. 4. Thoracic or lumbosacral neuritis or radiculopathy-724.4 5. Unspecified myalgia and myositis-729.1 5. Essential hypertension, benign-401.1 **Treatment:** Lumbago. Due to the patient's refractory symptoms, we will request authorization for bilateral L2-3, and L4-5 medial branch radiofrequency ablations. The risks and benefits of the procedure were explained in detail to the patient. 2. Chronic pain syndrome. Increase Hydrocodone 7.5-325mg tab, 1 tab orally, every 6 hours as needed for pain, 30 days, 120, refills 1. Start Naproxen 500 mg tab, 1 tab, orally, twice a day, 30 days, 60, refills, 1. 3. Thoracic or lumbosacral neuritis or radiculopathy. Increase Gabapentin 300mg capsule, 1 capsule, orally, three times a day, 30 days, 90, refills 1. 4. Unspecified myalgia and myositis Refill Cyclobenzaprine HCl tab, 10 mg, orally, three times a day, 30 days, 90, refills 1.

01/23/2015: UR. **Rationale for Denial:** Claimant sustained an industrial low back injury in 2013. No surgery is documented. Documented treatment to date has included medications, physical therapy, work conditioning, epidural steroid injections, sacroiliac joint injections, and 10/23/14 bilateral facet injections at L2/3/4/5. Request for repeat facet injections was denied following peer review and denial was upheld on appeal. 12/19/14 office note stated that claimant was previously awaiting radiofrequency ablation but procedure was not done due to treating physician relocating. Currently he reported sharp pain and tenderness in the lower back with radiation to the left lower extremity. Severe tenderness was noted to deep palpation over the lumbar spine and bilateral paraspinal musculature. Lumbar range of motion was limited and painful. No focal neurological deficits were documented. 11/13/14 and 12/19/14 office notes did not document response to 10/23/14 injections. Current pain level on 11/13/14 was 9/10. There is insufficient documented information concerning response to previous diagnostic facet joint blocks to meet ODG criteria for radiofrequency neurotomy. There was no opportunity to speak with requesting provider.

02/06/2015: Office Visit. **HPI:** The patient is here for a follow up and is reporting his lower back pain continues with radiating pain left groin. We reviewed his lumbar MRI which finds facet Arthropathy at levels L2-3 and L4-5. He previously had bilateral facet injections at these levels on 10/23/2014. The patient reports he had some pain with the injections for several days but then reports 50% relief for a day. Due to this relief we recommended radio frequency ablation of these levels, L2-3 and L4-5. We will request authorization again. **Assessment:** Lumbosacral spondylosis without myelopathy-721.3 (Primary) 2. Lumbago-724.2 3. Chronic pain syndrome-338.4 4. Thoracic or lumbosacral neuritis or radiculopathy-724.4 5. Unspecified myalgia and myositis- 729.1 5. Essential hypertension, benign-401.1 7. Encounter for long-term (current) use of other medications. **Treatment:** Lumbago. Due to the patient's refractory symptoms, we will request authorization for bilateral L2-3, and L4-5 medial branch radiofrequency ablations. The risks and benefits of the procedure were explained in detail to the patient. 2. Chronic pain syndrome. Increase Hydrocodone 7.5-325mg tab, 1 tab orally, every 6 hours as needed for pain, 30 days, 120, refills 1. Refill Naproxen 500 mg tab, 1 tab, orally, twice a day, 30 days, 60, refills, 1. 3. Thoracic or lumbosacral neuritis or radiculopathy. Refill Gabapentin 300mg capsule, 1 capsule, orally, three times a day, 30 days, 90, refills 1. 4. Unspecified myalgia and myositis Stop Cyclobenzaprine HCl tab, 10 mg 1 tab, orally, 3 times a day, 30 days. Start Baclofen 10mg tab, 1 tab, orally, at bedtime, 30 days, 30, refills 1.

02/24/2015: UR. **Rationale for Denial:** Submitted documentation indicates that this xx year old claimant fell and injure the lower back on xx. Currently, the claimant complains of progressive pain in the low back and left lower extremity. The claimant has difficulty ambulating and completing some activities of daily living. Treatment to date has included physical therapy, medications, epidural steroid injections, and bilateral facet injections at L2-3 and L4-5 on 10/23/14. The claimant reports some pain with the injections for several days, but then reports 50 percent relief for a day. Physical examination reveals severe tenderness to palpation in the lumbar spine and bilateral paraspinal musculature with left lumbar

paraspinal spasms. Range of motion flexion is 30 degrees, extension is limited due to pain, rotation is within normal limits, but painful and lumbar facet loading is positive bilaterally. MRI on 11/07/13 reveals mild facet Arthropathy at L2-3, slight retrolisthesis of L4 on L5 medial branch radiofrequency ablations and refill of medications including Hydrocodone, Naproxen, Gabapentin, and Baclofen. Regarding left L2-3 and L4-5 medial branch radiofrequency ablations, ODG provides criteria including positive response of at least 70 percent relief from preliminary diagnostic medial facet blocks. Given the claimants limited response to facet injections on 10/23/14, the medical necessity of the requested radiofrequency ablation is not supported. Non-certification is recommended.

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

The previous adverse determinations are upheld. Claimant is a xxyo who had a fall and injury on xx. Currently, the claimant complains of progressive pain in the low back and left lower extremity and complains of difficulty ambulating and difficulty completing some activities of daily living. Treatment to date has included physical therapy, medications, epidural steroid injections, and bilateral facet injections at L2-3 and L4-5 on 10/23/14. Claimant reports 50% relief for one day post treatment. In order to justify radiofrequency ablations, per ODG, claimant must report positive response of at least 70 percent relief from preliminary diagnostic medial facet blocks. Given the claimants limited response to facet injections on 10/23/14, the medical necessity of the requested radiofrequency ablation is not supported. Therefore, this request is non-certified.

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)**