Health Decisions, Inc.

PO Box 110
Keene, TX 76059
P 972-800-0641
F 888-349-9735

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Repeat Facet joint radiofrequency neurotomy left L4, L5, and SI medial blocks (64635-64636)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: American Board Certified Physician in Anesthesiology with Experience in Pain Management, with more than 10 years' 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]:
XX DOB: XX-XX-XX suffered from a work related injury on XX/XX/XX. Per records he was lifting a tarp that weighed approximately 150 lbs and injured his low back. He has been treated with ESI in the past. And he has undergone percutaneous laser assisted discectomy twice. Request is for Repeat Facet joint radiofrequency neurotomy left L4, L5, and SI medial blocks (64635-64636)

XX/XX/XX: Office note: The pt stated that on today's visit that he has been feeling constand moderately severe pain in the lower back area. Pain is constant sharp and stabbing. The low back pain appears to be made a lot worse by bending, driving, lifting, pulling, pushing, standing, stooping and walking. Mr. XX feels that taking pain pills and hot showers makes him more comfortable. He states that he has developed constant moderately severe right hip pain. Pt rates pain in low back 5/10, right hip 5/10, right foot 5/10 and left foot 5/10. Gait is normal he is able to transfer and ambulate around the room. Lumbar ROM has decreased. Medications: Norco 10/325 1 QD, Klonopin 1mg QHS, Effexor 150mg QD, Neurontin 100mg Q8hrs prn.

XX/XX/XX: Procedure note: Procedure: #1 Medial Branch Blocks Left L4, L5, S1 Pre-op diagnosis- L-spine Post- op: same

XX/XX/XX: Procedure note: Procedure RFNA Left L4, L5, S1 Medial Branches Pre and Post op diagnosis: Lumbosacral Spondylosis

XX/XX/XX: Office note: Pt reports about 60% relief after procedure. But he states the pain is gradually returning. Pt denies any significant problems with medications. UDS performed today for compliance. Start Ibuprofen 800mg BID. Decrease Norco 10/325 to 1 pill Q4-6 hrs.

XX/XX/XX: Procedure note: Procedure: RFNA Left L4, L5, S1 Medial Branches. Pre and Post op diagnosis: Lumbosacral

Spondylosis

XX/XX/XX: Office note: Pt complains of low back pain. After procedure he reports pain is about 85% better since RFNA. He is now having left greater trochanteric pain rates 3/10. Continue medications and try cutting back on Norco. Follow up in x months

XX/XX/XX: Office note: Pt complains of low back pain. He reports that he is still receiving about 20-30% improvement after RFNA on XX/XX/XX. He admits to overtaking his medication to decrease pain. He is about 21 pills short today. I let him know that I will not refill them early and if he is short again I will not prescribe them. Rates pain 2/10. Diagnosis: Lumbar Disc Displacement Herniation, Neuralgia, Neuritis and Radiculitis, Post laminectomy Syndrome of Lumbar Region, Lumbosacral Sprain, Trochanteric Bursitis, S/P RFNA with good relief. UDS performed today results discussed with pt and sent to lab for conformation.

XX/XX/XX: Office note: Pt reports that he is having pain today. He apparently overtook the Norco from last time due to increased pain. I have discussed with patient this and I will only write for 30 days of norco and he will have to find another provider for his norco. He does have increased tenderness in the Low back on the left. Continue other medications. I would consider repear of RFNA of the Left L4,L5 and S1 MB's Follow up in 6 months.

XX/XX/XX: UR: In my judgement, the clinical information provided does not establish the medical necessity of this request. This request is not supported within the current ODG guidelines.

XX/XX/XX: UR: In this case there is no documentation showing that the claimant has achieved long term pain relief and increase in function from prior radiofrequency. Therefore, the request for is not established as medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse determinations are upheld. There is no documentation showing that the claimant has achieved long term pain relief and increase in function from prior radiofrequency. Per ODG, this is a requirement to justify subsequent blocks. Therefore, the request for Repeat Facet joint radiofrequency neurotomy left L4, L5, and SI medial blocks (64635-64636) is not established as medically necessary and the request is non-certified.

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.

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)**