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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L2-L5 Rhizotomy Injection

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

This case was reviewed by a Board Certified Doctor of 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.

PATIENT CLINICAL HISTORY [SUMMARY]:
XX/XX/XX: Encounters Summaries. **HPI:** Ankle bilateral and lower back work injury. Date of onset was XX/XX/XX **Physical Exam:** XX year old male. No exercise intolerance, no sweat, fever, weight gain/loss. **Assessment/Plan:** Laceration over tibial tubercle. Atfl pain, no cfl pain. No pain in midfoot, no pain with calcaneal compression. Bilaterally for ankles. 1. Sprain of ankle 2. Fracture of lumbar spine. Return to see XX XX/XX/XX.

XX/XX/XX: CT L Spine without contrast. **Impression:** 1. No lumbar compression fracture is identified. 2. 2 mm non-obstructive left kidney stone. 3. 7mm non-obstructive calcification or adjacent calcifications in the right kidney lower pole. 4. Hazy edema and fecal fluid accumulation in the subcubivous tissue of the lower back region which could be dependent edema, contusion or focal inflammatory process.

XX/XX/XX: Encounters Summaries. **Medications:** AndroGel 20.25mg/1.25 gram (1.62%) transdermal gel pump, cephalexin 500mg capsule, Medrol (Pak) 4 mg tablets in a dose pack-take as directed, oxycodone-acetaminophen 7.5 mg-325 mg tablet, prednisone 20 mg tablet, sertraline 100 mg tablet, tramadol 50 mg tablet. **HPI:** The patient was injured when he became trapped in rafters between elevator and ceiling. Associated symptoms: no weakness, no numbness; no tingling; no swelling; no redness; no warmth; no ecchyrriosis; no catching/locking; no popping, clicking; no buckling; no instability; no change in bowel/bladder habits. Patient arrived with walking boots on bilateral ankles, the patient states he is still having pain in his ankles and lower back but it is getting better with time. **Physical Exam:** Soft tissue palpation of the ankle/foot right: no tenderness of the tibialis posterior, the tibialis anterior the plantar fascia, the Achilles tendon, the peroneus longus and brevis, the

extensor halluces longus, the sinus tarsi, the lateral anterior talofibular ligament, the anterior talofiular ligament, the calcaneofibular ligament, the posterior talotibular ligament, the deltoid ligament, or the retrocalcaneal bursee; no tenderness with palpation of syndesmosis: and Thompson test for Achilles tendon rupture intact. Soft tissue palpation of the ankle/foot Left: tenderness of the deltoid ligament. Edema around [1-[2, laceration 10 cm across lumbar area. I have ordered Molecular testing to determine the efficacy of the patient's current medication so as to rule out any possible adverse drug interactions as well as to eliminate the further use of medications that are not being properly metabolized/seek alternative drug choices that are more appropriate for this patient. A comprehensive study of the CYP-450 system as conducted by Molecular Testing Labs is necessary in determining the aforementioned as well as to gain information related to blood clotting factors to potentially mitigate complications resulting from possible surgery, etc. **Assessment/Plan:** 5 short of neutral, 25 degrees 5 inv, neutral eversion. 1. Sprain of ankle. The patient was advised on RICE therapy and was instructed to continue with home exercises, which were demonstrated. The patient is follow up in 4 weeks.

XX/XX/XX: Encounters Summaries. **HPI:** Patient arrived in ankle stirrups and he states he has done about 5 sessions of physical therapy and has helped with pain relief. **Physical Exam:** Ankles and Feet: Inspection Right: no erythema, induration, drainage, ecchymosis, warmth, or deformity and normal alignment and edema. Inspection left: no drainage, induration, erythema, ecchymosis, warmth or deformity and normal alignment and edema. Soft Tissue palpation of the ankle/foot right: no tenderness of the tibialis posterior, the tibialis anterior, the plantar fascia, the Achilles tendon, the peroneus longus and brevis, the extensor halluces longus, the sinus tarst the lateral anterior taofibular ligament, the anterior talofinbular ligament, the calcaneofibular ligament, the posterior talofibular ligament, the deltoid ligament, or the retro calcaneal bursae no tenderness with palpation of syndesmosis and Thompson test for Achilles tendon rupture intact. Soft Tissue Palpation of the Ankle/Foot Left: no tenderness of the tibialis posterior, the tibialis anterior, the plantar fascla, the Achilles tendon, the peonaus longus and bravis, the extensor hallucislongus, the sinus tarsi, the lateral anterior talofibular ligament, the anterior talofibular ligament, the calcaneofiular ligament, the posterior talofibular ligament, the deltoid ligament, or the retrocalcaneal bursae, no tenderness over syndesmosis and bale to actively flex and extend at the ankle. No pain with palpation over the syndesmosis and Thompson test for Achilles tendon rupture intact. Active ROM right: Inversion (5°) and eversion (10°). Active. ROM left: Inversion (5°) and eversion (10°). **Assessment/Plan:** 1. Fracture of lumbar spine-Closed fracture of lumbar vertebra without mention of spinal cord injury. Compression fracture of the spine after your visit, Norco 7.5mg-325 tablet- Take 1-2 tab by mouth every 4-6 hours as needed for pain, not to exceed 9 tabs per day. Qty: 40. Transcutaneous electrical nerve stimulators (TENS) device, Pain management referral. Note to provider: ESIS injection, please evaluate and treat. 2. Sprain of ankle

XX/XX/XX: Evaluation. **HPI:** He has been diagnosed with close fracture of the lumbar spine without mentioning spinal cord injury, also bilateral ankle sprain. He was given some walking boots and subsequently some ankle stirrup braces. He is currently going to physical therapy in XX. He states that he feels he is not really getting better with his low back or his ankles and rates his pain as being 7/10. He does have numbness and tingling of the lower extremities. His pain is worse with all positions and relieved with lying down. **Physical Exam:** This is a pleasant male in no acute distress. He has bruising on the lumbar spine at around L2-L3. ROM of the lumbar spine is limited in all planes. Straight leg raise testing is positive bilaterally about 30°. Motor strength is maintained. Reflex is equal and symmetrical. Vascular exam of lower extremities is normal. On inspection of the ankles, he has limited ROM of the ankles bilaterally with pain on inversion with pain to palpation of the deltoid ligament. Waddell's Nonorganic signs were tested: Simulated axial loading-negative, Simulated rotation-negative, General overreaction to examination-negative, Superficial tenderness-negative, Regional weakness-negative, Widespread, non-anatomic pain-negative, Regional sensory deficit-negative, Distracted straight leg raising-negative. **Impression:** Status post work related injury with significant traumatic injury of the lumbar spine as well as bilateral ankles. I am concerned about herniated disc with radicular symptoms. There is no evidence of compression fracture on the CT, but MRI would delineate the disc better. I would also like to see the ligament of the ankles on MRI testing. Therefore, MRI of the lumbar spine as well as ankles is ordered. Follow up after MRI and prescribe back brace.

XX/XX/XX: MRI L Spine without contrast. **Impression:** No disk herniation, spinal canal or foraminal narrowing present in the lumbar spine. No marrow edema noted to suggest recent injury to the lumbar vertebrae.

XX/XX/XX: MRI Left Ankle without contrast. **Impression:** 1. Suspect healing fracture through the superior aspect of the anterior calcaneal process. No bony bridging. Subtle early/mild sclerosis along the margins of the fragment. Marrow edema present within the fragment and in the adjacent calcaneus, possibly reactive change/stress reaction. Alternatively, (less likely given patient history of injury), the findings could potentially represent a developmental unfused ossicle (os caloancus secondaries), with marrow edema/stress reaction in the ossicle and adjacent calcaneus. Correlation with pain radiographs is recommended. Thin section CT imaging may imaging may be helpful for more detailed characterization.

XX/XX/XX: Evaluation. **HPI:** He continues to have moderate low back pain. He is attending PT two days a week. His current medications are Norco 10/325 mg and baclofen 10 mg. He also continues to have bilateral ankle pain; however, this is improving with PT and he is under the care of an orthopedic surgeon regarding his bilateral ankle and calcaneal fractures. He has not yet received his back brace that was previously ordered. Recent MRI of the lumbar spine appears normal. **Physical Exam:** Patient is in mild distress regarding his low back pain and walks with an antalgic gait. His lumbar spine is limited in ROM with flexion and extension, more so with extension. Positive Faber's test. Positive Gaenslen's test. Straight leg raises bilaterally produce moderate low back pain. Bilateral lumbar paraspinal pain with palpation is noted. Pain is also noted with palpation of his lumbar facet joints and with loading of facet joints. His neurological exam is overall intact to motor, sensory and reflex testing. **Plan:** Bilateral L3 to L5 medial branch block, the patient verbalizes understanding of the procedure and the risks and benefits associated with procedure. He also verbalizes understanding of preoperative instructions. He will continue PT and his current medication. Follow up with ortho regarding bilateral ankle fracture.

XX/XX/XX: Evaluation. **HPI:** The bilateral L2-L5 medial branch block is done; however, these were denied by insurance company. Again, this patient had significant injury of the lumbar spine with lumbar facet strain or injury and ability to get benefits from lumbar facet medial branch blocks. Medication is baclofen 20 mg pot id and Norco 10/325 mg one po q6h. **Exam:** He is alert and oriented x 3. Afebrile. Vital signs are stable. Speech is clear. No aberrant behavior. No drug behavior. Urine tox screen as well as pain contract. **Plan:** He was explained the risks and benefits of chronic narcotic therapy. We will await injection therapy, which will be important for diagnostic as well as therapeutic standpoint.

XX/XX/XX: Encounters Summaries. **HPI:** No weakness, tingling, swelling, numbness, redness, warmth, ecchymosis, no catching, locking, popping, clicking, buckling or grinding. No instability or weakness. Patient states that his back still hurts a lot. Right ankle is better, but left ankle is still in a lot of pain. He wants to know if he can have more PT. **ROS:** Ankles and Feet: Inspection right: no erythema, induration, drainage, edema, ecchymosis, warmth or deformity and normal alignment. Inspection Left: no edema. Soft tissue palpation of the ankle/foot right: no tenderness of the tibialis posterior, the tibialis anterior, the plantar fascia, the Achilles tendon, the peroneus longus and brevis, the extensor halluces longus, the sinus tarsi, the lateral anterior talofibular ligament, the posterior talofibular ligament, or the retrocalcaneal bursae, no tenderness with palpation of syndesmosis; tenderness of the anterior talofibular ligament and the calca__ ofibular ligament and Thompson test for Achilles tendon rupture intact; Achilles insertion pain. Plantar calcaneal pain. Soft tissue palpation of the ankle/foot left: no tenderness of the tibialis posterior, the tibialis anterior, the plantar fascia, the Achilles tendon, the peroneus longus and brevis, the extensor halucis longus, the sinus tarsi, the lateral anterior talofibular ligament, the posterior talefibular ligament, or the tretrocalcaneal bursae: no tenderness over syndesmosis: tenderness of the anterior talofibular ligament and the calcaneofibular ligament and able to actively flex and extend at the ankle. No pain with palpation over the syndesmosis, and Thompson test for Achilles tendon rupture intact. **Assessment/Plan:** 1.Fracture of the lumbar spine 2. Sprain of ankle. The patient was given a prescription for Medrol Dosepak.

XX/XX/XX: Encounters Summaries. Procedure Documentation: Cortisone injection into the right ankle.

XX/XX/XX: Operative Report. Lumbar facet medial branch block, bilateral L3, L4, and L5. Postoperative Diagnoses: 1. Chronic low back pain. 2. Facet dysfunction

XX/XX/XX: Evaluation. **HPI:** The patient returns for follow-up visit regarding his chronic low back pain post lumbar injection. The patient states that the received very good pain relief of his lumbar spine post lumbar facet and medical branch block injections. He states that he received at least 70% to 80% improvement of his low back pain. He is scheduled to be released from physical therapy next week. He continues to wear a back brace when he is working. **Physical Exam:** His lumbar spine shows improved ROM. His lumbar spine is limited more so with extension. Negative Faber's test. Negative Gaenslens's test. Bilateral straight leg raises are negative. His neurological exam is intact to motor, sensory and reflex testing. **Plan:** Continue PT until release. Follow up one month.

XX/XX/XX: Office Visit. **HPI:** Patient stated he aggravated his low back pain x1 week ago. He previously received steroid injections of his lumbar facets and medial branch block on XX/XX/XX with excellent benefit. He states he received at least 80-90% pain relief of his lumbar spine post facet injections. He has completed PT and is performing low back exercises at home. **Exam:** Increased lumbar pain with loading of facet joints. ROM: Forward Flexion: 85°, hyperextension: 25°. Lying straight leg raise: Right: positive in back only, left: positive in back only. Fabere Test: Right: positive, Left: positive. Waddell's Nonorganic signs Simulated axial loading: Negative. Simulated rotation: negative. General overreaction to examination: Negative Superficial tenderness: negative. Regional weakness: negative. Widespread, nonanatomic pain: negative. Regional sensory deficit: negative. Distracted straight leg raising: negative. **Plan:** Return to the clinic post-procedurally for follow-up.

XX/XX/XX: Operative Report. Left lumbar facet rhizotomy of L3, L4, and L5, medial branch of the dorsal ramus. Use of C-arm fluoroscopy. **Post-operative diagnoses:** 1. Lumbar facet dysfunction 2. Chronic low back pain

XX/XX/XX: Evaluation. **HPI:** He states that he has lumbar facet rhizotomy performed on the left side diminished his pain from a 6/10 to 1/10. He is still having right-sided low back pain symptoms. He had lumbar facet medial branch block at L3 through L5 bilaterally with very good results on the right side as well. **Physical Examination:** ROM of the lumbar spine is limited in extension. Pain to palpation of the right lower lumbar paraspinal at L3-4, L4-5 and L5-S1. Pain on facet joint loading of the lower lumbar spine. **Impression:** Persistent right-sided lumbar facet dysfunction with excellent response to previous right L3 through L5 median branch block. Right sided low back pain with excellent response to medial branch block at right L3 through L5. **Plan:** Rhizotomy of the right L4-5 and L5-S1 facet joints.

XX/XX/XX: UR. **Rationale for Denial:** The patient is a male who sustained an injury on XX/XX/XX when a protruding object snagged his clothing and pulled him down between the elevator and hoist way shaft. The patient is diagnosed with chronic low back pain and facet dysfunction of the lumbar spine. A request is made for right L2-L5 rhizotomy injection. CT scan of the lumbar spine showed no lumbar compression fracture. There was hazy edema and focal fluid accumulation in the subcutaneous tissue. MRI of the lumbar spine showed no disc herniation, spinal canal or foraminal narrowing in the lumbar spine. Prior treatments include medication and PT. He had lumbar facet medial branch block on the bilateral L3, L4 and L5 on XX/XX/XX. The medical report dated XX/XX/XX states that the patient has chronic low back pain post lumbar injection. He received very good pain relief of his lumbar spine post lumbar facet and medial branch block injections. He received at least 70% to 80% improvement of his low back pain. He is scheduled to be released from PT. He continues to wear a back brace when he is working. Medication wise, he is taking Norco. On physical examination of the lumbar spine, his lumbar spine showed improved ROM. His lumbar spine is limited more so with extension. There is negative Fabe test, negative Gaenslen's test and negative bilateral straight leg raise test. His neurological exam is intact to motor, sensory and reflex testing. The patient underwent left lumbar facet rhizotomy of L3, L4 and L5 medial branch of the dorsal ramus on XX/XX/XX. An updated medical report with recent comprehensive physical examination was not submitted for review. While a right L3-L5 rhizotomy injection is considered, the clear rationale for a right L2 rhizotomy injection was not elaborated. A prior diagnostic MBB involving the right L2 level was not documented. Moreover, evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy was not documented. As such, the medical necessity of this request has not been substantiated.

XX/XX/XX: UR. **Rationale for Denial:** The patient is a male who sustained an injury on XX/XX/XX when a protruding object snagged his clothing and pulled him down between the elevator and hoist way shaft. An appeal

request is made for right L2-L5 rhizotomy injection. The previous request was denied because of the lack of information regarding the patient's response to a prior diagnostic block, involving the right L2 level and taking into account the lack of evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy, the request is not indicated. While a right L3-L5 rhizotomy injection is considered, the clear rationale for a right L2 rhizotomy injection was still not elaborated. A prior diagnostic MBB involving the right L2 level was not documented. Moreover, evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy was still not documented. In agreement with the previous determination, the medical necessity of the request has not been established.

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

Claimant is a male who sustained an injury on XX/XX/XX when a protruding object snagged his clothing and pulled him down between the elevator and hoist way shaft. This request is for right L2-L5 rhizotomy injection. The previous request was denied because of the lack of information regarding the patient's response to a prior diagnostic block involving the right L2 level. Additionally, there is no demonstration of failure of conservative care in addition to facet joint therapy. While a right L3-L5 rhizotomy injection is considered, the clear rationale for a right L2 rhizotomy injection was still not elaborated. A prior diagnostic MBB involving the right L2 level was not documented. Therefore, this 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)**