

# Independent Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Fax: 817-549-0310

Notice of Independent Review Decision

**DATE OF REVIEW:** August 21, 2008

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Cervical Facet (C2-3) injections

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Denial Letters 6/26/08 and 7/16/08

Record from Dr. 6/10/08

Records from Clinic 4/11/07 thru 5/9/08

OP Report 1/7/08

Letter 8/8/08

Ortho 1/30/08

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a man who reportedly sustained work related injury in xx/xx. He underwent anterior cervical disc fusion (C4-5, C5-6 and C6-7) in January 2008. He developed temporoparietal headaches and neck pain that goes to the posterior head and occiput post surgery. Dr. found limited cervical motion, facet tenderness and a normal neurological examination (6/10/08), but Dr.'s PA noted absent left sided C5, C6, C7 reflexes. (4/24/08) but symmetrical at other times. A postoperative cervical xray done on 4/7/08 showed no "acute abnormality." He had no improvement with physical therapy. The preoperative cervical CT myelogram showed multiple levels of degenerative changes, but none were described at C2-3. The cervical MRI (1/30/07) described degenerative changes in the mid to lower cervical spine, but "At C2/3, there is no disc disease." There was "facet hypertrophy at C3/4 and C4/5" but none was described at C2-3.

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

The ODG refers the reader to facet problems when cervicogenic headaches protocols are requested.

The treating doctor apparently feels the headaches are cervicogenic in origin. The ODG describes facet symptoms as:

Facet joint pain, signs & symptoms

Recommend diagnostic criteria below. The cause of this condition is largely unknown, and the diagnosis is one of exclusion. One commonly cited cause is "whiplash injury" ([Lord 1996](#)). The most common cervical levels involved are generally C2-3 and C5-6 ([Barnsley, 2005](#)). The condition has been described as both acute and chronic, and includes symptoms of neck pain, headache, shoulder pain, suprascapular pain, scapula pain, and upper arm pain. ([Clemans, 2005](#)) Signs in the cervical region include: (1) tenderness to palpation in the paravertebral areas (over the facet region); (2) decreased range of motion; & (3) absence of radicular and/or neurologic findings. ([Fukui, 1996](#)) Diagnosis is made with controlled comparative blocks as uncontrolled blocks are associated with high false-positive rates. See [Facet joint diagnostic blocks](#); [Facet joint radiofrequency neurotomy](#); [Facet joint therapeutic steroid injections](#).

The ODG does not recognize facet RF neurotomy for cervicogenic headaches, but the current request is not for radiofrequency treatment.

Cervicogenic headache, facet joint neurotomy

Not recommended. Facet joint radiofrequency neurotomy is not recommended for cervicogenic headaches. A recent randomized controlled trial on patients diagnosed with this condition (based on clinical criteria), involved treatment with radiofrequency neurotomy at the C2-C6 facet joints ipsilateral to the pain. At three months the patients with neurotomy were somewhat improved, but at latter outcome measures (up to 24 months) there was no difference between patients in the sham control group from the 6<sup>th</sup> month measurement onward. ([Stovner, 2004](#)) See also [Greater occipital nerve block, diagnostic](#); & [Greater occipital nerve block, therapeutic](#).

Facet injections are also under scrutiny. They are generally considered for a neurotomy. The criteria does include not performing them on a level that had prior surgery. The prior

fusion was at C4 and below, not at C2-3 and C3-4. These criteria apply for diagnostic blocks.

#### Facet joint diagnostic blocks

Recommended prior to facet neurotomy (a procedure that is considered “under study”). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBB. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 27% to 63%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself....

#### **...Criteria for the use of diagnostic blocks for facet nerve pain:**

1. One set of diagnostic medial branch blocks is required with a response of  $\geq 70\%$ . The pain response should be approximately 2 hours for Lidocaine.
2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally.
3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
4. No more than 2 joint levels are injected in one session (see above for medial branch block levels).
5. Recommended volume of no more than 0.5 cc of injectate is given to each joint
6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.
7. Opioids should not be given as a “sedative” during the procedure.
8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.
9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.
10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated.

#### **11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.**

While the ODG does not recommend therapeutic facet steroid injections, it also has criteria for them that excludes their being performed in someone with a prior fusion. Those performed should be limited to 2 levels or less. Therefore, the requested procedure is not medically necessary.

#### Facet joint therapeutic steroid injections

Not recommended. There is one randomized controlled study evaluating the use of therapeutic intra-articular corticosteroid injections. The results showed that there was no significant difference between groups of patients (with a diagnosis of facet pain secondary to whiplash) that received corticosteroid vs. local anesthetic intra-articular blocks (median time to return of pain to 50%, 3 days and 3.5 days, respectively). ([Barnsley, 1994](#)) There is only one prospective, non-randomized study evaluating the use of medial branch blocks for chronic cervical pain (diagnosed with comparative, controlled blocks that were performed under “light sedation”). The trial did not differentiate the results between patients that received local anesthetic from those that received steroids, and all patients received Sarapin with in their injectate. ([Nelemans-Cochrane, 2000](#)) ([Manchikanti, 2004](#)) ([Manchikanti, 2003](#)) ([Boswell, 2007](#))

While not recommended, criteria for use of therapeutic intra-articular and medial branch blocks, if used anyway:

1. No more than one therapeutic intra-articular block is recommended.
2. **There should be no evidence of radicular pain, spinal stenosis, or previous fusion.**

3. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive).

**4. When performing therapeutic blocks, no more than 2 levels may be blocked at any one time.**

5. If prolonged evidence of effectiveness is obtained after at least one therapeutic block, there should be consideration of performing a radiofrequency neurotomy.

6. There should be evidence of a formal plan of rehabilitation in addition to facet joint injection 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)**