SENT VIA EMAIL OR FAX
ON Dec/29/2008

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/28/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Bilateral Cervial Medial Branch Block C2/C6, PT 2 X 5 sessions, Repeat MRI cervial spine and bilateral NCV upper extremities

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
Subspecialty Board Certified in Electrodiagnostic
Medicine Residency Training PMR and
ORTHOPAEDIC SURGERY

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY
This xx year old man was in rear ended in motor vehicle accident on xx/xx/xx. Dr. saw him on 5/6/08 and described neck pain and pain going to both shoulders and arms with numbness in hands. The cervical examination showed restricted motion and pain. There was no neurological exam. He advised physical therapy. He was again seen on 11/6/08 for similar neck pain going to the right shoulder and limited cervical motion. Dr. described local tenderness, but there was no neurological report wanted to perform a bilateral medial nerve
branch block and requested another MRI before “neuroaxial intervention.” He also

requested
nerve conduction studies.

An MRI done 7/22/08 showed degenerative disc changes with mild cervical spondylosis from C3-C7 with mild C5/6 central stenosis . There was no report of cord compromise. There was no foraminal stenosis and no nerve root compression described.

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

There are several requests and they are discussed separately.

MRI

First, there is the request for an MRI. This was done in July. There is no information of any symptom worsening or new injury to warrant a new study. The criteria supplied in the ODG are for the first MRI. There is no reason for a second one so soon after the first and the Reviewer can not approve this study. .

Magnetic resonance imaging (MRI

Not recommended except for indications list below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. (Anderson, 2000) (ACR, 2002) See also ACR Appropriateness Criteria™. MRI imaging studies are valuable when physiologic evidence indicates tissue insult or nerve impairment or potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery. MRI is the test of choice for patients who have had prior back surgery. (Bigos, 1999) (Bey, 1998) (Volle, 2001) (Singh, 2001) (Colorado, 2001) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic
resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007

Indications for imaging -- MRI (magnetic resonance imaging)

- Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms presen

- Neck pain with radiculopathy if severe or progressive neurologic defici

- Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms presen

- Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms presen

- Chronic neck pain, radiographs show bone or disc margin destructio

- Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal

- Known cervical spine trauma: equivocal or positive plain films with neurological deficit

Nerve Conduction Studies.

The request is for nerve conduction studies and not an emg. The value of NCV is limited in

the examination of the cervical spine. It can be useful in the diagnosis of a peripheral neuropathy. There are symptoms suggestive of carpal tunnel syndrome based on the symptoms. There is no neurological examination provided to determine if this person has motor loss or reflex loss to justify an emg (not requested). The EMG has values in the determination of a radiculopathy. It is felt to be an extension of the neurological examination. Again, none was described in this patient. The NCV combined with the emg may give better insight if a radiculopathy or double crush injury exists. Since only the NCV studies were requested, the Reviewer can not approve them. The shoulder pain can be a symptoms of a radiculopathy, but without the request of EMG, the Reviewer can not comment further.

Nerve conduction studies (NCS

Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective.

Electromyography (EMG

Recommended (needle, not surface) as an option in selected cases. The American Association of Electrodiagnostic Medicine conducted a review on electrodiagnosis in relation to cervical radiculopathy and concluded that the test was moderately sensitive (50%-71%) and highly specific (65%-85%). (AAEM, 1999) EMG findings may not be predictive of surgical outcome in cervical surgery, and patients may still benefit from surgery even in the absence
of EMG findings of nerve root impingement. This is in stark contrast to the lumbar spine where EMG findings have been shown to be highly correlative with symptoms

Positive diagnosis of radiculopathy: Requires the identification of neurogenic abnormalities in two or more muscles that share the same nerve root innervation but differ in their peripheral nerve supply.

Timing: Timing is important as nerve root compression will reflect as positive if active changes are occurring. Changes of denervation develop within the first to third week after compression (fibrillations and positive sharp waves develop first in the paraspinals at 7-10 days and in the limb muscles at 2-3 weeks), and reinervation is found at about 3-6 month

Acute findings: Identification of fibrillation potentials in dennervated muscles with normal motor unit action potentials (usually within 6 months of symptoms: may disappear within 6 weeks in the paraspinals and persist for up to 1-2 years in distal limbs)

Chronic findings: Findings of motor unit action potentials with increased duration and phases that represent reinnervation. With time these become broad, large and polyphasic and may persist for years

Anatomy: The test primarily evaluates ventral (anterior) root function (motor) and may be negative if there is dorsal root compression (sensory) only. Only C4-8 and T1 in the neck region have limb representation that can be tested electrodiagnostically. The anatomic basis for this lies in the fact that the cervical nerve roots have a motor and a sensory component. It is possible to impinge the sensory component with a herniated disc or bone spur and not affect the motor component. As a result, the patient may report radicular pain that correlates to the MRI without having EMG evidence of motor loss.

Paraspinal fibrillation potentials: May be seen in normal individuals and are nonspecific for etiology. The presence of these alone is insufficient to make a diagnosis of radiculopathy and they may be absent when there is a diagnosis of radiculopathy secondary to sampling error, timing, or because they were spared. They may support a diagnosis of radiculopathy when corresponding abnormalities are present in the limb muscles

Indications when particularly helpful: EMG may be helpful for patients with double crush phenomenon, in particular, when there is evidence of possible metabolic pathology such as neuropathy secondary to diabetes or thyroid disease, or evidence of peripheral compression such as carpal tunnel syndrome.

H-reflex: Technically difficult to perform in the upper extremity but can be derived from the median nerve. The test is not specific for etiology and may be difficult to obtain in obese patients or those older than 60 years of age.

(Negrin, 1991) (Alrawi, 2006) (Ashkan, 2002) (Nardin, 1999) (Tsao, 2007) See Discectomy- laminectomy-laminoplasty. (Surface EMG and F-wave tests are not very specific and therefore are not recommended. For more information on surface EMG, see the Low Back Chapter.)

The Reviewer has no records how this person had been previously treated in the 10 months since the accident. There was another physician. The Reviewer suspects she had therapy then, but the Reviewer has no records. The ODG does support the role of therapies in the treatment of cervical disc problems and radiculopathy. This can be used in conjunction with cervical injections. It would be useful to know if he had any PT up to this time.

Physical therapy (PT

Recommended. Low stress aerobic activities and stretching exercises can be initiated at home and supported by a physical therapy provider, to avoid debilitation and further restriction of motion. (Rosenfeld, 2000) (Bigos, 1999) For mechanical disorders for the neck, therapeutic exercises have demonstrated clinically significant benefits in terms of pain, functional restoration, and patient global assessment scales. (Philadelphia, 2001) (Colorado,
2001) (Kjellman, 1999) (Seferiadis, 2004) Physical therapy seems to be more effective than general practitioner care on cervical range of motion at short-term follow-up. (Scholten- Peeters, 2006) In a recent high quality study, mobilization appears to be one of the most effective non-invasive interventions for the treatment of both pain and cervical range of motion in the acutely injured WAD patient. (ConlinI, 2005) A recent high quality study found little difference among conservative whiplash therapies, with some advantage to an active mobilization program with physical therapy twice weekly for 3 weeks. (Kongsted, 2007) See also specific physical therapy modalities, as well as Exercise

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial"

Cervicalgia (neck pain); Cervical spondylosis (ICD9 723.1; 721.0)

9 visits over 8 week

Sprains and strains of neck (ICD9 847.0)

10 visits over 8 week

Displacement of cervical intervertebral disc (ICD9

722.0) Medical treatment: 10 visits over 8 week

Post-injection treatment: 1-2 visits over 1 wee

Degeneration of cervical intervertebral disc (ICD9 722.4)

10-12 visits over 8 weeks

Facet joint diagnostic blocks

There is a role for facet joint injections. The cause of neck pain post “whip lash” remains unknown. There is some evidence that the facets and the disc can be the pain generators. A diagnostic facet injection may be appropriate if there is no radicular pain. I do not see a neurological examination to exclude this and other possibilities. This should be done before proceeding.

Facet joint pain, signs & symptom

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.

Facet joint diagnostic block

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

Technique: The described technique of blocking the medial branch nerves in the C3-C7 region (C3-4, C4-5, C5-6, and C6-7) is to block the named medial branch nerves (two injections). Authors have described blocking C2-3 by blocking the 3rd occipital nerve. Another technique of blocking C2-3 is to block at three injection points (vertically over the joint line, immediately above the inferior articular facet at C2 and immediately below the superior articular facet at C3). (Barnsley, 1993) The volume of injectate for diagnostic medial branch blocks must be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate) as increased volume may anesthetize other potential areas of pain generation and confound the ability of the block to accurately diagnose facet pathology. (Washington, 2005) (Manchikanti , 2003) (Dreyfuss, 2003) See the Low Back Chapter for further references

Criteria for the use of diagnostic blocks for facet nerve pain

Clinical presentation should be consistent with facet joint pain, signs & symptoms.

1. One set of diagnostic medial branch blocks is required with a response of ≥ 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 join

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

12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE

GUIDELINES [ ] MILLIMAN CARE GUIDELINES

[X] 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)