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Notice of Independent Review Decision

DATE OF REVIEW: 2/1/08

IRO CASE #:

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

This case was reviewed by a Pain Management Specialist, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral Cervical Facet Injections at C4-C5

REVIEW OUTCOME:

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

Upheld (Agree with prior noncertification)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o April 11, 2001, Cervical Myelogram with Post Myelogram Cervical CT, Dr.
- o January 14, 2003, CT of the Cervica Spine, Dr.
- o January 21, 2004, CT Scan of the Cervical Spine without Contrast, Dr.
- o May 6, 2005, CT of the Cervical Spine with Reconstruction, Dr.
- o September 16, 2005, MRI of the Cervical Spine with and without Contrast, Dr.
- o August 9, 2006, New Patient Evaluation, Dr.
- o September 28, 2006, Medical Evaluation for Cope Program, PA-C
- o January 16, 2007, New Patient History and Physical Examination, Dr.
- o June 27, 2007, Orthopedic Report, Dr.
- o July 3, 2007, Esophagram, Dr.
- o July 11, 2007, Follow-Up Visit, Dr.
- o July 12, 2007, Follow-Up Visit, Dr.
- o July 12, 2007, Radiology Report, Dr.
- o June 13, 2007, Follow-Up Visit, Dr.
- o September 4, 2007, Follow-Up Report, Dr.
- o September 26, 2007, Follow-Up Report, Dr.
- o September 26, 2007, MRI of the Cervical Spine, Dr.
- o October 4, 2007, Follow-Up Visit, Dr.
- o October 29, 2007, Follow-Up Visit, Dr.
- o November 19, 2007, Peer Review Report, Dr.
- o November 19, 2007, Case Management Notes, RN
- o December 10, 2007, Return Office Visit, Dr.
- o December 14, 2007, Case Management Notes, RN
- o December 19, 2007, Reconsideration Peer Review Report, Dr.
- o December 19, 2007, Case Management Notes, RN

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient sustained an industrial injury. The patient is status post cervical fusion at C5-C6 performed on June 10, 2002 with anterior plate removal at C6-C7 performed on May 30, 2003. The patient underwent a repeat cervical fusion in November 2004 from C5-C7 as well as a right shoulder rotator cuff repair on March 29, 2007. The initial peer reviewer recommended non-certification for the requested cervical facet injections as the medical

records did not clearly establish that the patient had active cervical facet disease. He noted that the patient had not improved with operative interventions and the records did not indicate whether interventional techniques had been attempted to address her radicular complaints.

On appeal, the peer reviewer noted that the patient had already undergone prior cervical facet joint injections/medial branch blocks that were of no benefit. He recommended non-certification for facet injections.

The patient was most recently evaluated on December 10, 2007, at which time the patient complained of cervical spine pain with radicular pain into the right upper extremity. Examination demonstrated markedly pain limited cervical range of motion and bilateral posterior element tenderness to palpation, right greater than left with facet loading. The treating physician is recommending intra-articular facet injections at C4-C5 and to consider cervical discography in the future for adjacent segment disease.

A CT scan of the cervical spine was performed on September 26, 2007, which demonstrated at C4-C5, a broad-based posterior disc protrusion lateralizing lightly to the left of midline measuring approximately 3 mm causing slight deformity of the left side of the thecal sac and spinal cord without direct cord contact. The AP diameter of the spinal canal is approximately 9-10 mm. Minimal narrowing of the right neural foramen is seen and there was a reversal of the normal lordotic curvature centered at this level. No evidence of facet arthropathy was noted at that level.

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

As noted above, the patient has already undergone prior cervical facet joint injections/medial branch blocks that were of no benefit. It would not be advisable to repeat such injections in absence of a positive response.

Additionally, as noted above, the most recent CT scan demonstrated a fairly significant disc protrusion at C4-C5 which causes slight deformity of the thecal sac and spinal cord. Additionally, right neural foraminal narrowing was noted. These findings would be more consistent with a neural compressive lesion and not facet joint mediated pain.

Furthermore, as noted in the references, cervical facet injections should be limited to patients with cervical pain that is nonradicular. Clearly, in this case, the patient complains of a radicular type pain. The patient has not met the appropriate criteria to proceed with this type of interventional pain management procedure.

Therefore, recommendation is to uphold the prior noncertification for bilateral cervical facet injections at C4-C5.

The IRO's decision is consistent with the following guidelines:

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

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- _____OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

ODG (2007) Facet signs and 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.

Official Disability Guidelines, 2007. Diagnostic facet joint blocks are recommended prior to facet neurotomy (a procedure that is considered "under study"). Pain relief after an injection of local anaesthetic (lidocaine or bupivacaine) into the facet joints is a very accurate diagnostic tool for assessing facet joint pain. Diagnosis can be made with both intra-articular facet joint injections and medial branch blocks. Confirmatory blocks are strongly suggested due to the high rate of false positives. At least one diagnostic block should be a medial branch block. Diagnostic blocks may be performed with the anticipation that if successful, treatment will proceed to facet neurotomy at the diagnosed levels. 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)

Criteria for the use of diagnostic blocks for facet nerve pain:

1. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally.
2. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
3. No more than 2 joint levels are injected in one session (see above for medial branch block levels).
4. A minimum of 2 diagnostic blocks per level are required, with at least one block being a medial branch block.
5. 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.
6. Opioids should not be given as a "sedative" during the procedure.
7. 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.
8. A response of ? 70% pain relief for the duration of the anesthetic used is required in order to progress to the second diagnostic block (approximately 2 hours for Lidocaine).
9. The diagnosis is confirmed with documentation of ? 70% pain relief with both blocks.
10. 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.
11. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated.
12. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.
13. Bilateral blocks are generally not medically necessary.