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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: May 21, 2008

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 PM&R Physician, 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

Facet joint injection with arthrogram, followed by post injection physical therapy x 1 session

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Submitted medical records were reviewed in their entirety.
Treatment guidelines were provided to the IRO.
December 5, 2008 Designated Doctor report from , MD
December 5, 2008 Work Status Report from Dr.
January 10, 2008 Follow-up note report from Dr. , partial, p. 1 only
February 16, 2008 Medical report and request for facet injections from Dr.
February 18, 2008 Request for reconsideration, facet blocks from Dr
February 29, 2008 Procedure report, facet injections with arthrogram from Dr.
March 11, 2008 Progress report with request for left suprascapular and left ganglion occipital nerve block from Dr.
March 14 through April 11, 2008 Nurse case manager notes,
March 17, 2008 Denial for request of facet injections
April 3, 2008 Request for reconsideration from Dr.
April 11, 2008 Denial of request for reconsideration facet injections
May 5, 2008 Request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews available for my review, the patient is a XX-year-old employee who sustained an industrial injury to the cervical spine on XX/XX/XX when struck in the left [or right] side of the neck and head by a 5 foot crowbar. She was seen by the company doctor and provided medications. A second company doctor prescribed Valium and butalbital (acetaminophen and caffeine) 325 mg. The patient then located a chiropractic provider at the end of September 2007. Radiographs were interpreted as negative. Following 2 months of care, 12 – 15 sessions, the patient told the provider the treatment was not helping.

Cervical MRI of September 26, 2007 shows a mild disc bulge of 2 mm without loss of disc height at C5-6 and a dorsal annular fissure with small concentric tears and no evidence of fracture. A brain scan was interpreted as normal with exception of an empty sella turcica syndrome (primary ESS is associated with obesity and hypertension in women).

A Designated Doctor Evaluation was provided on December 5, 2007. The patient is described as 5' 1" and 220 pounds. The patient saw a neurologist through her private physician and Topamax was prescribed but was not helpful. The patient has not worked since September 26, 2007. She has also been recently prescribed Skelaxin, Lyrica, amitriptyline (tricyclic antidepressant), ibuprofen and Tramadol. On examination, cervical flexion was to 30 degrees and extension to 25 degrees. Soft tissue tenderness was noted at C4-6 and the left trapezius region. Motor and sensory functions were intact. The patient will be MMI in about 3 months. She has a mild head concussion and a soft tissue myofascial strain to the paravertebral musculature. She can work light duty.

On examination of February 16, 2008, it was reported that the patient has a numbness and tingling sensation and loss of power at the division of the C5 and C6 distribution as well as tenderness at the left side of the facet at C5-C6. The diagnosis includes bilateral facet pain and possible cervical radiculopathy at the C5-6 level. Recommendation was for reconsideration for a diagnostic facet injection for left cervical facet arthropathy to clarify the facets as a possible pain generator. 50% relief would provide evidence of facet mediated pain and radiofrequency ablation would then be requested.

On February 18, 2008 request was made for reconsideration for left cervical facet joint injection with arthrogram, followed by 1 session of post injection physical medicine x 1 session.

Per nurse notes, the request for reconsideration was approved by a physician advisor on February 22, 2008 with rationale that radiculopathy was not substantiated on physical examination. The request is for a diagnostic injection with possible radiofrequency ablation to follow.

A Procedure Report of February 29, 2008 describes cervical facet injections into the left cervical joints at 5 levels, C7-T1, C6-7, C5-6, C4-5 and C3-4 with arthrogram at the same levels.

On March 6, 2008 six days post-injection, the patient reported good relief with the injection with better left lateral neck motion and overall relief of 65%, but the effect is wearing off. She rates her pain as 6/10. She also reports weakness in the left leg.

Per a progress report of March 11, 2008 the patient reports tingling in her lower extremities. She reports 60% improvement of her left cervical muscle spasms but continues to complain of right-sided tightness and stiffness and we would like to do right-sided facet injections as well. She also has significant suprascapular neuritis bilaterally left greater than right as well as occipital neuritis and tightness and we would like to perform a left suprascapular and left ganglion occipital nerve block. On examination, tenderness over the cervical midline and left facets was noted. The patient demonstrated numbness and tingling sensation and loss of power at the division of the C5 and C6 level.

On March 17, 2008 request for a second cervical facet injection was not certified in review with rationale that, per guidelines, studies on facet injections are insufficient to recommend facet injections. There should also be a concurrent formal rehabilitation program in progress. In addition, there should be no evidence of radicular pain. Success is defined as 50% relief for at least 6 weeks. If successful the provider should proceed to radiofrequency ablation. The patient was less than 2 weeks from an initial injection, there was evidence of radiculopathy and the medical records failed to document any benefit from the post injection physical medicine.

The patient returned on March 18, 2008. The patient reports more spasm and neck pain. She reports more tingling and numbness going to both her hands and a pain level today of 8-9/10. She also reports weakness in both hands, especially at nighttime and early morning. Recommendation is for left greater occipital nerve block and left suprascapular nerve block with a single session of chiropractic manipulation followed by the procedure.

On April 8, 2008 request was made for reconsideration of denial of cervical facet injections.

On April 11, 2008 a final consideration for cervical facet injection was not certified in review with rationale that adequate supporting medical documentation showing the request was appropriate was not submitted. Per a telephone discussion with the provider's assistant, there was no additional clinical information available to support the request. The prior rationale for denial continued to apply.

On May 5, 2008 the provider requested an IRO.

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

The medical records document denial of repeat cervical facet injections due report of subjective signs of radiculopathy and lack of support in the guidelines for repeat facet injections when an initial diagnostic injection fails to provide at 50% relief for at least 6 weeks. The initial injection provided relief of less than a week and the patient reported pain of 6/10 at day 6.

The treatment plan prior to injection stated, request is for a diagnostic injection with possible radiofrequency ablation to follow. If a diagnostic injection is successful, per guideline requirements, the provider should proceed to a medial branch diagnostic block and, if positive, then proceed to radiofrequency ablation. If an initial diagnostic injection is not successful, the facets have not therefore been identified as the primary pain generator and the treatment plan should be reassessed. In this regard, it is noted

that the provider subsequently requested left greater occipital nerve block and left suprascapular nerve block with a single session of chiropractic manipulation followed by the procedure. The response to that request has not been reported.

It is also noted by this reviewer that the physical examination findings of March 6 and March 11 and March 18 are exactly the same without fresh insight or verbiage. Guidelines require a concurrent formal rehabilitation program in progress when injections are being provided which has not been reported. Per a Designated Doctor evaluation the patient has a mild head concussion and a soft tissue myofascial strain to the paravertebral musculature and was anticipated to be MMI by approximately March 5, 2008. The medical records fail to substantiate a medical necessity for cervical facet injections. Therefore, my determination is to agree with the previous non-certification of the request for cervical facet joint injection with arthrogram, followed by post injection physical therapy x 1 session.

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
- 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

The Official Disability Guidelines – 5-7-2008:

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.