



Medical Review Institute of America, Inc.  
America's External Review Network

DATE OF REVIEW: October 29, 2008

IRO Case #:

**Description of the services in dispute:**

Items in dispute: #64626X1 RFTC Cervical facet injections and #64627X6 RFTC cervical additional levels C2-C7 and 3rd occipital nerve #00600 and #77003

**A description of the qualifications for each physician or other health care provider who reviewed the decision**

The physician providing this review is board certified in Anesthesiology and is a doctor of Osteopathy. The reviewer is currently an attending physician at a major medical center providing anesthesia and pain management services. The reviewer has participated in undergraduate and graduate research. The reviewer has been in active practice since 1988.

**Review Outcome**

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

Upheld

**Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.**

The request for #64626X1 RFTC Cervical facet injections and #64627X6 RFTC cervical additional levels C2-C7 and 3rd occipital nerve #00600 and #77003 is not medically necessary.

**Information provided to the IRO for review**

**Records from the State:**

- Notice to Medical Review Institute of Case Assignment, 10/13/08
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization, 10/10/08
- Company Request for IRO
- Request for a Review by an Independent Review Organization, 10/2/08
- Adverse Determination Letter, 9/17/08
- Adverse Determination Letter, 9/17/08

Records from the Provider:

- Notice of Assignment of Independent Review Organization, 10/13/08
- Request for a Review by an Independent Review Organization, 10/2/08
- Letter, MD, 9/27/08
- Adverse Determination Letter, 9/17/08
- Follow-up Evaluations, MD, 8/20/08, 5/28/08, 6/27/07, 5/1/07, 2/26/07, 2/2/07
- Operative Report, pages 1 and 2, MD, 2/9/07
- Consultation, MD, 10/19/05
- Operative Report, pages 1 and 2, MD, 9/20/05
- CT Cervical spine report, 3/1/05
- MRI Brain report, 6/24/08

Records from the Insurance Company:

- Notice to Utilization Review Agent of Assignment of Independent Review Organization
- Adverse Determination Letter, 9/17/08
- Preauthorization Request Form, 9/3/08
- Follow-up Evaluations, MD, 8/20/08, 5/28/08, 6/27/07, 5/1/07, 2/26/07, 2/2/07, 8/20/08, 5/28/08
- Progress note, MD, 10/5/07
- Operative Report, pages 1 and 2, MD, 2/9/07
- Operative Report, pages 1 and 2, MD, 9/20/05
- Consultation, MD, 10/19/05
- CT Cervical spine report, 3/1/05
- Adverse Determination Letter, 9/17/08
- Preauthorization Request Form, 9/3/08
- Adverse Determination Letter, 9/8/08

Patient clinical history [summary]

The patient is a xx year-old female with a date of injury in xx/xx. The patient had left C2-7 RF in 5/06 and 2/07. The patient also had left 3rd occipital nerve RF at the same time. The patient had Botox to the neck and head in xx/xx. With this combined therapy she had about 75% relief until 5/08. The patient has questionable Spurling sign on the left and evidence of CTS on the left.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The request involves more than 2 cervical facet joint levels, which is in excess of ODG recommendations for RF. The pt had Botox a month after RF so it is virtually impossible to determine how much each treatment benefited her, as both were directed to the same area. For these reasons, repeat RF is not medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

ACOEM pg 175, 176

ODG: 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 = 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.

AND: Facet joint radiofrequency neurotomy

Under study. Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis. Studies have not demonstrated improved function. One randomized controlled trial was performed on patients with neck pain at the C3 to C7 level after a motor vehicle accident. There was a success rate of 75% with one or two treatments with a median time to return to a 50% preoperative level of pain of approximately 9 months. (Lord, 1996) A similar duration of pain relief (219 days) was found in a prospective non-randomized trial.

Complete pain relief was obtained by 71% of patients (for a “clinically satisfying period”). (McDonald, 1999) A recent retrospective review was conducted on patients with diagnosed cervical facet syndrome (via controlled blocks) and found that 80% of patients had pain relief with a mean duration of 35 weeks per injection. The mean duration of relief was less at the C2–3 joint than at other levels, and was also less for patients on compensation (non–significant difference). Pain was not measured with a formal pain rating instrument. (Barnsley, 2005) (ConlinII, 2005) The procedure is not recommended to treat cervicogenic headaches (See Facet Joint radiofrequency neurotomy, Cervicogenic Headaches). Potential side effects include painful cutaneous dysesthesias, increased pain due to neuritis or neurogenic inflammation, and cutaneous hyperesthesia. (Boswell, 2005) The clinician must be aware of the risk of developing a deafferentation centralized pain syndrome as a complication of this and other neuroablative procedures. This procedure is commonly used to provide a window of pain relief allowing for participation in active therapy. (Washington, 2005) Evidence is lacking to support intra–articular steroid injections or radiofrequency neurotomy. (Haldeman, 2008) See also Cervicogenic headache, facet joint neurotomy. See the Low Back Chapter for further references.

Criteria for use of cervical facet radiofrequency neurotomy:

1. Treatment requires a diagnosis of facet joint pain. See Facet joint diagnostic blocks.
2. While repeat neurotomies may be required, they should not be required at an interval of less than 6 months from the first procedure. Duration of effect after the first neurotomy should be 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 depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function.
4. No more than two joint levels are to be performed at one time (See Facet joint diagnostic blocks).
4. If different regions require neural blockade, these should be performed at intervals of not sooner than one week, and preferably 2 weeks for most blocks.
5. There should be evidence of a formal plan of rehabilitation in addition to facet joint therapy.