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Notice of Independent Review Decision

DATE OF REVIEW: 4/5/09

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 (Board Certified), 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

Repeat right C5-C7 medial branch blocks

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 21, 2006 Thoracic MRI read by Dr..
- December 21, 2006 Cervical MRI read by Dr.
- November 16, 2007 EMG/NCV report read by Dr.
- December 13, 2007 New Patient office visit report from Dr.
- December 14, 2007 Neurosurgical consultation report from Dr.
- January 7, 2008 Cervical MRI read by Dr.
- January 7, 2008 Cervical radiographs read by Dr.
- January 16, 2008 Follow-up report from Dr.
- February 13, 2008 Follow-up report from Dr.
- July 24, 2008 Unsigned physician notes from Pain Center
- December 8, 2008 Authorization request form from Dr.
- December 30, 2008 Non-authorization Recommendation from
- January 28, 2009 Reconsideration Decision: Non-authorization from
- March 18, 2009 Request for IRO
- March 27, 2009 Notice of IRO assignment

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient is a employee who sustained an industrial injury to the neck on approximately xx-xx-xx. The incident of injury is slow onset of neck pain.

Cervical spine MRI was performed on December 21, 2006 and shows straightening of the cervical lordosis. Severe endplate

degenerative change, disc height loss and disc desiccation most severe at C6-7. Cervical spondylytic change and degenerative disc disease is seen to a lesser degree at C5-6. No significant disc bulge or herniation is observed at 2-3, C3-4, C4-5 or C7-T1. The neural foramina are widely patent bilaterally at these levels. At C5-6 there is minimal posterior osteophyte ridging and uncovertebral joint hypertrophy. There is mild posterior central disc protrusion which projects left of midline which partially effaces the ventral thecal sac on the left without cord compression. At C-6 there is concentric disc bulge with associated posterior osteophyte ridging and uncovertebral joint hypertrophy which yields moderate to severe bilateral neural foraminal encroachment. The bony spur-disc complex flattens the ventral spinal cord.

Thoracic radiographs of December 21, 2006 show varying degrees of endplate degenerative change and degenerative disc disease at all thoracic levels with evident mild posterior disc protrusions at T2-3, T3-4, T4-5 and T7-8. There is a left paracentral posterior disc protrusion at T2-3 which contacts the ventral thoracic cord on the left without significant deviation or compression.

Electrodiagnostic studies were performed on November 16, 2007 and showed delayed onset latencies of the median motor and sensory nerves bilaterally indicating a compressive demyelination process, which is consistent with entrapment and/or neuritis.

The patient was evaluated in pain management on December 13, 2007 in regard to right cervical radiculopathy. He has been treated conservatively but his pain has worsened. His pain is primarily in the right lower cervical and right scapular area as well as the right forearm and hand. He also noted intermittent tingling and numbness in the three middle fingers and right forearm. He pain ranges from 4-9/10. He noticed some decreased strength in his right upper arm which has improved with therapy. He is using Flexeril and ibuprofen. He is set up for a neurologic evaluation. He had back surgery at L3-5 in 1990. On examination, there is good cervical range of motion. There is decreased sensation in the right upper distal extremity beginning approximately mid-forearm and in all the fingers on the palmar side and all fingers except his right 5th finger on the dorsum. Assessment is cervical radiculitis, muscle spasm and cervical disc displacement without myelopathy. We will schedule him for cervical epidural steroid injections.

A neurology report of December 17, 2007 indicates the patient notes the patient may have a C7 radiculopathy as well as a double crunch injury from carpal tunnel syndrome. He has only just begun conservative treatments. He should continue physical therapy another 15-20 visits. Updated MRI of the cervical and thoracic spine are recommended. On examination, motor strength is full with exception of 4.75 upper right extremity strength. Sensation is normal with exception of second, third and fourth fingers with decreased pinprick sensation, right volar forearm with decreased perception of pinprick to the elbow, and right anterior shin.

Updated cervical MRI was performed on January 7, 2008 and shows at C5-6 a disc herniation and canal stenosis with cord deformity. No cervical nerve root compression is seen, but there is potential for irritation of exiting nerve roots at levels C5-6 and C6-7. Updated cervical x-rays of the same date show multilevel cervical spondylytic change with C6-7 disc degeneration change with greater than 80% loss of disc height, moderate spondylytic change with endplate spur directly in the spinal canal up to 4 mm at the same level. There is mild to moderate spondylytic change at C5-6, endplate spur directly in the spinal canal up to 3 mm. No abnormal movement detected between neck flexion and neck extension in the upright position.

On January 16, 2008 the patient was approved for six additional sessions of physical therapy. MRI shows a C6-7 herniation. He is scheduled for his first epidural injection. Diagnosis includes right cervical radiculopathy. The medical report of February 13, 2008 indicates the patient is doing physical therapy. His first epidural injection is scheduled for February 14, 2008.

A handwritten and mostly illegible treatment note of July 24, 2008 indicates the patient is status post a second cervical epidural injection with not as much response as with the initial epidural injection. His diagnosis is cervical fact syndrome and cervical radicular pain syndrome. Recommendation is for cervical facet medial branch block at right C5-7 levels.

An undated authorization request form which may be of date December 8, 2008 indicates the patient has a diagnosis of neck pain, cervical spondylosis and post laminectomy syndrome cervical. Request is for cervical medial branch block C5-7 under fluoroscopy and mild sedation. Per handwritten notes dated December 8, 2008 the patient is noted to have felt like a new person following right C5-7 medial branch block on August 14, 2008. However, his axial neck and right arm pain have returned. Baclofen and Motrin are helpful. His MMI examiner did not believe a cervical herniation is possible with desk work. Recommend repeat C-7 right medial branch block.

Request for repeat right C5-C7 medial branch block was not certified in review on December 29, 2008 with rationale that ODG recommends no more than one set of medial branch diagnostic blocks prior to facet neurotomy; they do not recommend medial branch blocks other than as a diagnostic tool. A peer-to-peer discussion was attempted but not realized.

Request for reconsideration for repeat C5-7 medial branch blocks was not certified in review on January 28, 2009 following a peer-to-peer discussion with rationale that ISIS Practice Guidelines state that cervical medial branch blocks are indicated when there is a need to know if the patient's pain is mediated by the medial branches of the cervical dorsal rami. ODG states that medial branch blocks are not recommended except as a diagnostic tool and that no more than one set of medial branch diagnostic blocks prior to facet neurotomy is supported.

Per a request for IRO dated March 18, 2009 handwritten by the clinician, the following services have been denied: cervical radiofrequency ablation performed 2-11-09, cervical medial branch block performed 1-28-09 and cervical medial branch block performed 1-30-09. A separate handwritten note indicates radiofrequency ablation was not denied by UR but by the adjuster.

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

The Official Disability Guidelines recommend facet blocks prior to facet neurotomy. ODG criteria for the use of facet blocks is one set of diagnostic medial branch blocks required with a response of = 70%. The pain response should be approximately 2 hours for Lidocaine. 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. A second block is not recommended. It is also noted that the authorization request form (undated) indicates procedures codes of facet injection (64470), fluoroscopy (77003) and mild sedation (99144) and, per The Official Disability Guidelines, 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. As ODG does not support a second diagnostic medial branch block, my determination, therefore, is to agree with the previous non-certification of the request for repeat right C5-C7 medial branch blocks.

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

The Official Disability Guidelines - Cervical: Facet Joint Diagnostic Blocks - March 19, 2009:

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 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.
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

The Official Disability Guidelines - Cervical: Radiofrequency Neurotomy - March 19, 2009:

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. (W ashington, 2005) Evidence is lacking to support intra-articular steroid injections or radiofrequency neurotomy. (Haldeman, 2008)
Factors associated with failed treatment: These include increased pain with hyperextension and axial rotation (facet loading), longer duration of pain and disability, significant opioid dependence, and history of back surgery. 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. Approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function.
3. 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.
6. 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.