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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 2, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed bilateral Cervical spine injections C4-5, C5-6, C6-7

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine.

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.81	64470, 64472		Prosp						Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO- 16 pages

Respondent records- a total of 20 pages of records received to include but not limited to: Records, Dr. 11.5.08-3.12.09; note 1.15.09; TDI notice of an IRO; letters 9.11.08, 2.16.09; WC patient information

Requestor records- a total of 43 pages of records received to include but not limited to:

letters 2.16.09, 3.12.09, 3.17.09; provider list; Dr. records 12.4.03-4.30.04; MRI Cervical spine 8.13.08; notes 8.14.08-2.26.09; note, Dr. 10.5.08; records, Dr. 11.5.08-2.4.09; ODG Neck-Upper back

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a male who sustained a work related injury on xx/xx/xx at which he slipped and fell fracturing his C1-2 region. This resulted in him being in a halo for 4 to 5 months. One week later after coming out of halo he turned his head and refractured his spine. This resulted in him having an operation with the bone fusion and wire wraps. He was again in a halo for about 3 months; then it was taken off. He then stepped out of a shower again fracturing his neck. He was reoperated at which rods were placed. Prior to his last surgery he was mainly being treated for instability, after the last surgery he has mainly had pain in his neck and head. He has a family history of Cancer, Diabetes, Headaches, Heart disease, Lupus, Rheumatoid arthritis. Allergies consist of penicillin and Neurontin.

12/04/03- Operation C1-2 instability- Surgeon: MD

Indications for procedure: Earlier immobilization with a halo ring and vest failed to stabilize his cervical spine. Intraoperative radiograph showed satisfactory reduction and positioning of the halo ring and vest system. Patient was awakened and taken into the recovery room. No complications noted.

04/30/04- Operation Non fusion, C1-C2, with unstable cervical spine resulting in cervical stenosis- Surgeon: MD

Patient did not maintain his reduction even with surgery performed on 12/04/03 and halo immobilization and developed subsequent cervical stenosis. He was placed in cervical traction and then when to operating room for definitive treatment. His wounds were dressed appropriately and the patient was taken to the ICU. No complication noted.

08/13/08- MRI C-Spine w/o contrast

Indication: Cervicalgia. Neck pain with right-sided pain with loss of feeling in the hand.
Impression: Appears to be an old fracture of the dens. Flexion and extension views may be of benefit to see if there is dynamic subluxation at this level. There has been anterior translation of the dens relative to the remainder of the C2 vertebral body. This creates cervical stenosis at the level of C1 and there is some cord signal abnormality in the posterior aspect of the cord at this same level. The remainder of the cervical spine is unremarkable in appearance.

08/14/08-02/26/09-Follow-up Visits- Dr. MS, PA-C , D.O.

Notes state patient is still at a pain scale of 1-2/10 with no improvement only with medications. Still complains of deep achy pain and radiation to his right upper extremity. He had an EMG done and results are not available for my review.

10/06/08- Consultation Report- Dr.

Impression: Status post OC fusion.
Plan: Watch, Mobilize, Flexion extension of the cervical spine in the monitoring.

10/23/08- Discharge Summary- Dr.

Final Diagnosis: Status post O C fusion.

Procedures performed: Trauma evaluation including head CT, C-spine CT, and CTA of the neck, all of which were without acute injury. MRI cord series.
No complications. Discharge the patient home with family.

10/30/2008: The patient is seen and evaluated by Dr & he documented in his progress note that there are no neurological deficits noted.

Neck pain.

Assessment: Post-lami syndrome, cervical

Cervical Spinal Stenosis

Cervical Radiculopathy

Plan: Post-Lami syndrome, cervical Start Lidoderm film, 5% applied topically, 30, 1 patch.

Consideration of the TENS trial to see if these help with pain, cervical epidural steroid injections, hardware block, greater occipital nerve blocks or peripheral nerve stimulation and ultrasound evaluation of posterior elements of cervical spine and upper back.

11/05/08- Progress Note- The patient was examined by the neurosurgeon & he documented the cervical Radiculopathy, but no evidence of neurological deficits noted. Dr.

12/11/2008 the patient is seen by Dr & he suggested that further instructions will be given by neurosurgeon's office & no active intervention is needed.

1/15/2008 the patient was seen at Dr 's office, the notes did not show any new physical changes as compared to 8/14/2008.

02/04/2009- Progress Note by Dr , he mentioned he is not a candidate for any additional surgeries. He mentioned that the blocks will provide temporary improvement.

Neck pain.

Assessment: Post-lami syndrome, cervical

Cervical Spinal Stenosis

Cervical Radiculopathy

Treatment: Recommend bilateral C4-5, C5-6, and C6-7 cervical facet joint injections. If patient gets good but short term relief, consider neurotomy. Patient shows little or no relief; consider epidural injections at a later time. If no improvement, consider peripheral subcutaneous spinal cord stimulation.

Procedure: Facet Joint Diagnostic Injection- Cervical: bilateral, C4/5, C5/6, C6/7.

02/16/2009 and - Denial letters for requested service description of a Cervical Injection C4/5, C5/6, C6/7

03/12/2009- Appeal letter denied for requested service description of a Cervical Injection C4/5, C5/6, and C6/7

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

The patient's history has been reviewed. The patient has recovered well overall without any neurological deficits. The patient's EMG is inconclusive shows root irritation. The patient positive findings are pain, which has already being treated with the pain medications. The ODG guidelines say the facet blocks are helpful to prove improvement, if the patient might benefit from facet neurotomy. The Neurotomy it self is under study. The ODG guidelines did not give a clear cut indication of timelines in which the facet blocks work. The efficacy of the facet blocks in injuries over 1 year is not mentioned clearly.

The ODG also says Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated.
 Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.

So, I recommend the request for the injections be denied at this time.

Facet joint diagnostic blocks	<p>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.</p> <p><i>Technique:</i> 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.</p> <p>Criteria for the use of diagnostic blocks for facet nerve pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms.</p> <ol style="list-style-type: none"> 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
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	<p>surgical procedure is anticipated.</p> <p>11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.</p> <p>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.</p>
Facet joint therapeutic steroid injections	<p>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)</p> <p>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)</p> <p>While not recommended, criteria for use of therapeutic intra-articular and medial branch blocks, if used anyway:</p> <p>Clinical presentation should be consistent with facet joint pain, signs & symptoms.</p> <ol style="list-style-type: none"> 1. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 2. If successful (initial pain relief of 70%, plus 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). 3. When performing therapeutic blocks, no more than 2 levels may be blocked at any one time. 4. If prolonged evidence of effectiveness is obtained after at least one therapeutic block, there should be consideration of performing a radiofrequency neurotomy. 5. There should be evidence of a formal plan of rehabilitation in addition to facet joint injection therapy. 6. No more than one therapeutic intra-articular block is recommended.

ODG: Cases Without Neurologic Findings (95% of cases)

- Also first visit (day 1):
 - o o Prescribe [decreased activity](#) if necessary based on severity and difficulty of job, passive therapy with [heat/ice](#) (3-4 times/day), [stretching/exercise](#), appropriate [analgesia](#) (i.e., acetaminophen) and/or anti-inflammatory (i.e., ibuprofen) [*Benchmark cost: \$14*], [back to work](#) except for severe cases in 72 hours, possibly modified duty. Avoid bed rest,
 - o o No [X-Rays](#) unless major trauma (e.g., a fall)
 - o o If muscle spasms, then prescribe [muscle relaxant](#) with limited sedative side effects [*Benchmark cost: \$44*]
 - o o Reassure patient: common problem (90% of patients recover spontaneously in 4 weeks)

ODG Return-To-Work Pathways (*847.0 neck sprain*)
 Whiplash grade 0 (Quebec Task Force grades): 0 days
 (See ODG Capabilities & Activity Modifications for Restricted Work under “[Work](#)” in Procedure Summary)

- Second visit (day 3-10 – about 1 week after first visit, or sooner, because [delayed treatment](#) is not recommended)

- o o Document progress (areas of tenderness, motor strength)
- o o If still 50% disabled then prescribe manual therapy [*Benchmark cost: \$250*]: Refer to [massage therapist](#), [chiropractor](#), [physical therapist](#), or [occupational therapist](#) (3 visits in first week), or by treating DO
- o o Probably discontinue muscle relaxant

ODG Return-To-Work Pathways (*847.0 neck sprain*)
Whiplash grade I-III, clerical/modified work: 5 days

- Third visit (day 10-17 – about 1 week after second visit)
 - o o Document progress
 - o o Prescribe muscle-conditioning [exercises](#)
 - o o At this point 66%-75% should be back to regular work
 - o o If still disabled, then first [imaging study](#) (AP/Lateral 2-view X-Ray of upper back) [*Benchmark cost: \$150*] to rule out cervical spondylolysis, or joint narrowing/spinal stenosis (age related, not caused by recent trauma – will not change treatment) [ICD9 721.3, 721.4, 724.02]
 - o o Continue therapist, change from passive to active modality, 2 visits in next week, teach home exercises
 - o o End manual therapy (PT or manipulation) at 4 weeks

ODG Return-To-Work Pathways (*847.0 neck sprain*)
Whiplash grade I-III, manual work: 21 days
Whiplash grade I-III, heavy manual work: 28 days

- Up to 3 more visits for follow up & documentation of progress

Source/Criteria: ACOEM Guidelines Citation Ref: Low Back Chapter 12, pages 300, 309; updated Chapter 12 page 180

According to ACOEM Guidelines:

Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery.

Citation: *Pain without Radicular Symptoms*

Epidural glucocorticosteroid injections are not recommended for acute, sub acute, or chronic LBP in the absence of significant radicular symptoms. They are also not recommended as first- or second-line treatment in individuals with LBP symptoms that predominate over leg pain. They are not recommended as treatment for any chronic problem.

Strength of Evidence – Not Recommended, Evidence (C)

I did speak to Dr Ken Light he says “Mr. Thomas Kennedy has been suffering from pain for last 3 months; The epidural injection is most conservative and would like to try it out”.

Conclusion:

The notes dated November 5th 2008 did not show any evidence of Radiculopathy; therefore, the request for: epidural injection at L5-S1 is being recommended for denial.

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

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES