



## IMED, INC.

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 11/24/09

**IRO CASE NO.:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Item in dispute: DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE, CERVICAL OR THORACIC/SINGLE LEVEL

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

Texas Board Certified Physical Medicine & Rehabilitation  
Fellowship Trained Pain Management

**REVIEW OUTCOME**

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

Denial Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. 101 pages of clinical including
2. X-rays of the cervical spine from 2006 and 2009
3. Office notes from Pain Consultants, M.D., additional provider Nurse Practitioner
4. Procedure notes from Ambulatory Surgery for Pain management, Dr.
5. Previous determination
6. Previous professional reviews from M.D.
7. MRI of the cervical spine
8. **Official Disability Guidelines**

**PATIENT CLINICAL HISTORY (SUMMARY):**

This employee is a male with a history of neck pain and cervical degenerative disc disease who has been undergoing pain management care through both medication management and procedures at the Pain Consultants.

Present in the medical records is a first visit date of xx/xx/xx.

There were two cervical spine x-rays available for review. These included x-rays on 07/10/06 showing straightening of the normal lordosis. There was borderline spondylolisthesis at C4-C5 with mild anterior osteophyte formation at C6. There was loss of disc space height at C4-C5 through C6-C7.

An additional x-ray of the cervical spine was taken on 10/14/09 which showed severe cervical spondylosis, especially at C4-C5, C5-C6, and C6-C7. There was intervertebral osteochondritis noted at C5-C6. Reversal of the normal cervical lordosis was seen from C3-C7.

On xx/xx/xx, we have the first office note from Pain Consultants. This noted that the employee had a history of a work related injury in xx/xxxx. He complained of ongoing chronic neck pain with pain that radiated to his right shoulder. Physical examination showed him to be awake and oriented times three; he had decreased range of motion in the shoulder with some decrease in flexion and extension. The diagnosis was herniated disc at C6-C7 with clinical C8 radiculopathy on the right. The plan was to proceed with epidural steroid injections and pain management through the use of medications.

On 12/05/03, the employee had his first cervical epidural steroid injection performed at C6-C7.

Since the 2003 timeframe, the employee has received well over forty pain management visits and or procedure visits. In 2003, these included cervical epidural steroid injections times two. In 2004, cervical epidural steroid injections time four. In 2005, cervical epidural steroid injections times two, selective nerve root block times one, C5-C6 bilateral rhizotomy, and cervical nerve root block times one. 2006 rhizotomy times one at C5-C6. 2007 rhizotomy times two at C5-C6. 2008 rhizotomy times one. 2009 rhizotomy times one.

There was a cervical MRI from 07/10/03. It was noted that there was only page one of this MRI available for review. There was straightening of the normal cervical curvature. There was disc desiccation through discs in the cervical range from C3-T1. Also, there was ankylosis of the C5-C6 vertebra. Secondary to trauma, surgery, or one of the ankylosis or spondylo arthropathies. The cervical cord signal intensity is normal. ADI index was normal. The cervical tonsils were normal in position with no subluxation seen.

The most recent pain off clinical note was from 08/24/09. At that time, the employee continued to have neck pain that did improve with previous rhizotomies. He was well over eight weeks since his last rhizotomy; he was rating his pain as a 9 on a scale of 0-10. He did have occasional drowsiness with pain medications. He noted only weekend use of Hydrocodone secondary to work. There was also some noted relief with

Tramadol. On examination, he was alert and cooperative; oriented and pleasant; he did have pain at the cervical spine midline paracervically as well as radius and pain into the shoulders bilaterally. Strength was intact in the upper extremities. Range of motion of the cervical spine was painful particularly on extension with limitation. Range of motion in the cervical spine was 50 degrees forward bending, 10 degrees extension with significant pain, 40 degrees left side bend, 30 degrees right side bend. Medications included Lyrica, Hydrocodone, Tramadol, Zanaflex, Metoprolol ER, Fexofenadine, Amlodipine, and Celexa. Diagnosis was herniated disc cervical, cervicgia, neck pain. The plan was to resubmit for repeat cervical rhizotomy.

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

Based on the **Official Disability Guidelines** current online edition regarding facet joint radiofrequency/neurotomy, this is a procedure that continues to be considered under study. Conflicting evidence is available as to the efficacy of this procedure and approval should be made on a case by case basis. The criteria for approval include 1) treatment requires diagnosis of facet joint pain. 2) Approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in the visual analog score, and documented improvement in function. 3) No more than two joint levels are to be performed at one time. 4) If different reasons require neural blockade, these should be performed at intervals if not sooner than one week and preferably two weeks for most blocks. 5) There should be evidence of formal plan of rehabilitation in addition to facet joint therapy. 6) While repeat neurotomies may be required, they should be not required in an interval of less than six months from the first procedure.

At this time, based on the current clinical guidelines found within the **Official Disability Guidelines** concerning the use of rhizotomy, medical necessity cannot be established at this time and the decision is to uphold the disapproval of the request for a cervical facet rhizotomy at the C5-C6 level. One note of concern from this reviewer's perspective is the fact that this employee has received multiple facet rhizotomies at this level, and although he does get some temporary relief from these, it is questionable that further referral and/or evaluation by a board certified orthopedic or neurologic surgeon would be the logical next step.

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

1. **Official Disability Guidelines**, Neck Chapter and Pain Chapter, online version
2. Jensen I, Harms-Ringdahl K. Strategies for prevention and management of musculoskeletal conditions. Neck pain. *Best Pract Res Clin Rheumatol*. 2007;21:93-108.
3. Laxmaiah Manchikanti, MD, Vijay Singh, MD, David Kloth, MD, Curtis W. Slipman, MD, Joseph F. Jasper, MD, Andrea M. Trescot, MD, Kenneth G. Varley, MD, Sairam L. Atluri, MD, Carlos Giron, MD, Mary Jo Curran, MD, Jose Rivera, MD, A. Ghafoor Baha, MD, Cyrus E. Bakhit, MD and Merrill W. Reuter, MD. **American Society of Interventional Pain Physicians Practice Guidelines**. *Pain Physician*, Volume 4, Number 1, pp 24-98, 2001.