

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/25/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral cervical medial branch block and facet joint injections, 64470 x 2, 64472 x 4, 76005 x 1

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

MD, Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 10/7/09, 10/22/09
MD, 10/1/09, 10/15/09, 10/23/09, 9/25/09, 8/26/09,
7/29/09, 7/15/09
MR Cervical w/o, 8/23/09, 6/23/09
Provider List, 7/15/09

PATIENT CLINICAL HISTORY SUMMARY

This is a woman who was reportedly injured on xx/xx/xx. There are notes in the record about a cabinet door or desk hitting her. Another note describes whiplash. She is known to have chronic pain. Her MRI showed generalized cervical degenerative changes with a small C5/6 HNP. She is on Oxycontin. NSAIDS did not help. She has limited cervical motion, local tenderness in the paraspinal regions and reported pain on facet loading. A neurological examination was not available in the reports. This request is for Bilateral cervical medial branch block and facet joint injections, 64470 x 2, 64472 x 4, 76005 x 1.

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

The patient has pain in the facet region and a reduced range of motion. There was no

neurological examination available for review however, so the reviewer is unable to determine if the patient meets ODG criteria for facet pain. In addition, ODG states that only two levels should be injected. The itemized list and the CPT codes in the request cite 3 levels on each side, or a total of 6 joint levels. This exceeds the guideline recommendations. The reviewer finds that medical necessity does not exist for Bilateral cervical medial branch block and facet joint injections, 64470 x 2, 64472 x 4, 76005 x 1.

Facet joint pain, signs & symptoms

Recommend diagnostic criteria below. The cause of this condition is largely unknown, and the diagnosis is one of exclusion. One commonly cited cause is “whiplash injury” (Lord 1996). The most common cervical levels involved are generally C2-3 and C5-6 (Barnsley, 2005). The condition has been described as both acute and chronic, and includes symptoms of neck pain, headache, shoulder pain, suprascapular pain, scapula pain, and upper arm pain. (Clemans, 2005) Signs in the cervical region include: (1) tenderness to palpation in the paravertebral areas (over the facet region); (2) decreased range of motion; & (3) absence of radicular and/or neurologic findings. (Fukui, 1996) Diagnosis is made with controlled comparative blocks as uncontrolled blocks are associated with high false-positive rates. See Facet joint diagnostic blocks; Facet joint radiofrequency neurotomy; Facet joint therapeutic steroid injections.

Facet joint diagnostic block

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) (Falco, 2009) 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 $\geq 70\%$. 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.

Facet joint therapeutic steroid injection

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) (Falco, 2009)

While not recommended, criteria for use of therapeutic intra-articular and medial branch blocks, if used anyway

Clinical presentation should be consistent with facet joint pain, signs & symptoms

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.

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

- ACOEM-AMERICA 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)