

SENT VIA EMAIL OR FAX ON
Aug/07/2009

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral Cervical Facet Injections Outpatient

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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

OD Guidelines
Denial Letters 6/18/09 and 7/8/09
Dr. 6/3/09
MRI 10/20/08
X-Ray 10/6/08

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured on xx/xx/xx after a fall. He has ongoing neck pain. The Cervical MRI was "unremarkable." The cervical xrays did not show pathology. There was no comment of any loss of the normal cervical lordosis. The only medical record provided was Dr. 's note of 6/3/09. He commented on some relief with cervical traction. His examination described local tenderness at the spinous processes and the left more than right cervical column. The

neurological exam was normal. His primary diagnosis is fibromyalgia with a secondary diagnosis of cervical strain. He wrote that he wanted to “determine if his facet joints are part of his pain generator. We will therefore recommend unilateral injections from C3-4 to C6-7 on a unilateral basis...” and if successful, then to consider neurotomies.

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

The first issue is does the exam meet the criteria of facet joint pain. The description by the ODG is somewhat generalized and recognizes that facet blocks can be needed to confirm the diagnosis. It also recognizes the incidence of false positive findings. Dr. is considering the diagnostic blocks at this time. The only indication for these is for the neurotomy he is considering. The latter is under study. The ODG only justifies the medial branch block rather than intra-articular injections. The Reviewer could not be sure which technique Dr. is considering. He is also asking to block from C3-4 to C6-7, 4 levels and the ODG only permits 2 levels at a session for diagnostic and therapeutic blocks. There was no information provided explaining the need for such a variance from the standards in the ODG. The Reviewer cannot overrule the prior decisions.

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 blocks

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 $\geq 70\%$. 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 injections

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](#))

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)