CLAIMS EVAL

Utilization Review and Peer Review Services

URAC ACCREDITED

DATE OF REVIEW: **7-19-11**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Injection, anesthetic agent, other peripheral nerve or branch-medial branch blocks at C4-5 and C5-6--Date of service 4/19/11-4/20/11

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

American Boards of Physical Medicine and Rehabilitation and Pain Management

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

9-23-09 MD., the claimant current complaints of low back and neck pain. The patient was injured onxx/xx/xx working for xx where he had worked for 14 years. The patient has had one surgery for this injury. He has had appropriate diagnostic testing and therapeutic procedures up to the present. The claimant is enthusiastic in participating in the PRIDE program.

9-24-09 MD., notes that this patient meets all criteria for a functional restoration program with proven outcomes. For the time being he will continue on his Hydrocodone
7.5 mg, being asked to restrict this to 30 mg daily. He will start on a psychotropic regimen of Cymbalta 30 mg increasing to 60 mg for his depressive symptoms and begin on Klonopin 0.5 mg up to b.i.d. p.r.n. He will use Celebrex as an NSAID and be seen again once authorized. No further interventional procedures are planed for him her until he has a trial of exercise only.

Follow up with Dr. r on 1-24-11 notes the recommendation or long term care plan consisting on quarterly doctor visits. He also recommended referral to Dr. for facet injections in the cervical area.

2-11-11 MD., the claimant was seen for an injection consultation. The claimant is a xx, who sustained a work-related injury to his neck and low back on xx/xx/xx. The Injury was sustained on xx/xx/xxand he underwent an ACDF in January 2009 by Dr. The patient had preoperative epidural steroid injections by Dr. in the neck as well as
2 epidural steroid injections in the lumbar spine. The patient was enrolled in a program of functional restoration here at PRIDE which he completed and the patient was placed at Maximum Medical Improvement as of 12/02/09. He has been followed here under Long-Term Care Plan since that time. He has had increasing neck pain most recently and he had been asked to see the patient to consider cervical facet injections. The claimant complains of centralized neck pain without radiation in a radicular pattern. There is no associated weakness, numbness, tingling, or paresthesias. On exam, cervical spine alignment is intact. Cervical lordosis is well maintained. Shoulders are level. Cervical motion is moderately restricted in flexion, extension, rotation, and side bending. Palpation reveals C4-C5, C5-C6, and C6-C7 tenderness over the facet joints with palpation in a supine position. Neurologically, deep tendon reflexes are 2/4 and symmetric at the biceps, triceps, brachioradialis, patella, medial hamstrings, and Achilles tendons. Motor power is normal and symmetric in dermatomal distributions of the bilateral upper extremities. Sensation is well preserved. Rapid alternating movements are

intact. Tandem gait is smooth and symmetric without antalgia, weakness, or spasticity. Clinical impression: Chronic neck and back pain status post work trauma with cervical segmental rigidity and facet tenderness. Recommendations:

recommend cervical facet injections to be done concurrent with a stretching program in which the patient was instructed to try and bring his symptoms back under control would propose bilateral C4-C5 and C5-C6 facets be injected to see if he cannot relieve some of these rigidity he has developed and provide the relief he Is looking for. The evaluator started the claimant on Medrol Dosepak and Vicodin.

2-17-11, MD., performed a Peer Review. The claimant is a male with a date of injury of xx/xx/xx. The mechanism of injury was not provided. The claimant has a diagnosis of cervical post-laminectomy syndrome. There was an ACDF performed at the C5-6 and C6-7 segments by Dr. on 01/08109. The claimant has received 2 prior ESI's. The claimant was seen by Dr. on 02/11/11 and there were complaints of cervical pain. On physical exam there was noted tenderness to the C4-5 to C6-7 levels. The claimant was given a Medrol dose pack and Vicodin. He was recommended to have a C4-5 and C5-6 cervical facet injection. The request for a bilateral C4-6 facet joint injection with fluoroscopy is not medically necessary. The claimant had an ACDF performed at the C5-6 and C6-7 segments on 01/08/09. The claimant has received 2 prior ESI's. The claimant was seen by Dr. on 02/11/11 and there were complaints of cervical pain. On physical exam there was noted tenderness to the C4-5 to C6-7 levels. The claimant was given a Medrol dose pack and Vicodin. The ODG states that while not recommended, criteria for use of therapeutic intra-articular and medial branch blocks, if used anyway include: "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. No more than one therapeutic intra-articular block is recommended." The reviewer spoke to (AP Designee) and informed her that the claimant has had a prior fusion at the requested level and therefore the request is not supported by ODG. She wished to amend the request to a therapeutic facet injection at the C4-5 level only. Even though this request was amended there is still no support for therapeutic facet joint injections in the cervical spine based on ODG. Therefore, the request is not medically necessary.

3-4-11 MD., the claimant has current complaints of low back and neck pain. The patient was injured on xx/xx/xx working for where he had worked for 14 years. The patient has had one surgery for this injury. He has had appropriate diagnostic testing and therapeutic procedures up to the present. On exam, cervical spine alignment is intact. Cervical lordosis is well maintained. Shoulders are Cervical motion is moderately restricted in flexion, extension, rotation, and side bending. There is minimal posterior cervical tenderness without overt paraspinal muscle spasm on direct palpation, but there is trapezius spasm lateralized to the left.

Neurologically, deep tendon reflexes are
2/4 and symmetric at the biceps, triceps, and brachioradialis tendons. Motor power is normal and symmetric in bilateral upper extremities. Clinical impression: Chronic neck pain after cervical fusion. The evaluator provided a refill for Hydrocodone and Robaxin. The claimant was given samples of Flector patches and Lidoderm patches.

4-13-11 MD., the claimant has current complaints of low back and neck pain. The patient was injured on xx/xx/xx working for where he had worked for 14 years. The patient has had one surgery for this injury. He has had appropriate diagnostic testing and therapeutic procedures up to the present. The patient denies medication allergies. Review of systems, past, family and social history are unchanged. The patient is 70" in height and weighs 149 pounds. The claimant returns today for follow-up of his chronic neck pain. He remains on Hydrocodone 7.6/326 mg 1 tablet p.a. t.i.d. and Robaxin 750 mg p.o. The Medrol Dosepak offered no significant improvement in symptoms. He has also been using the Flector patch, but these are irritating his skin. Examination of the cervical spine reveals no skin rash or lesion today. Cervical motion is severely restricted in all planes of motion with significant rigidity. Moderate posterior tenderness is noted over the facet joints. Examination of the knee reveals a moderate effusion. There is medial joint line tenderness. There is no ligamentous instability. Impression: Chronic neck pain after cervical fusion, right knee Injury with effusion (noncompensable). Recommendations: refill Hydrocodone, see PCP for right knee. Recheck to see if he can proceed with medial branch blocks.

Follow up with Dr. on 4-18-11 notes the claimant is to continue with long term care. His medications include Hydrocodone and Robaxin.

4-19-11 UR review performed by DO., notes that the medial branch blocks C4-5 & C5-6
Explanation of findings: No, the request for medial branch blocks C4-C5 and C5-C6 is not medically necessary or appropriate. The reviewer was unable to approve medial branch blocks at C4-C5 and C5-C6 as the claimant had a prior fusion and this is not consistent with Guidelines' recommendation for a facet block. Therefore, non- certification. ODG TWC Neck & Upper Back.

5-4-11 Letter of reconsideration: "I am in receipt of an adverse determination regarding our request for medial branch block at C4, C5, and CB bilaterally. Dr. reviewed this ease and stated that this was not medically reasonable or necessary as the patient had a previous cervical fusion. The information we have available to us indicates that the fusion was performed at C5-C6 and C6-C7. It is the C4-C5 zones we are attempting to denervate and routine anatomy would indicate that C4, C5, and C6 medial branch blocks will be necessary to provide adequate coverage of this joint above fusion. As such, we would respectfully request reconsideration of this plan of treatment."

5-11-11 UR performed by MD., reflects an Adverse Determination. This is a request for medial branch blocks at C4-5 and C5-6. Based on the medical evidence provided, this request has been determined to not be supported for medical necessity. The Official Disability Guidelines indicates that medial branch blocks/diagnostic facet blocks require a clinical presentation consistent with facet

joint pain, signs and symptoms. These include axial neck pain ("either with no radiation or rarely past the shoulders"), tenderness to palpation in the paravertebral/facet area, decreased range of motion; and absent of radicular and/or neurologic findings. "If radiation to the shoulder is noted, pathology in this region should be excluded." The guidelines also provide additional criteria as follows: (1) One set of diagnostic medial branch blocks is required with a response of greater than or equal to 70% pain relief lasting at least two hours if injection is with local anesthetic such as Lidocaine. There is indication that if the injection utilizes steroids, there should be at least 50% pain relief for at least 12 weeks. (2) Limited to patients with cervical spine pain that is nonradicular and at no more than two levels bilaterally. (3) There is documentation of failure of at least four to six weeks of conservative treatment including home exercise, physical therapy and anti-inflammatories. (4) No more than two joints levels are injected in one session. (5) The patient should have documented 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; (6) Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level or in whom a surgical procedure is anticipated. (7) It is currently not recommended to perform cervical facet injections on the same day as epidural steroid injections, stellate ganglion blocks, sympathetic blocks or trigger point injections. In this individual's case, there is inconsistency about the patient's radiation of pain into the upper extremity. As an example, in the note of 09/23/09, there is indication that the patient had radiation into the upper extremities. Yet, in the note of 02/11/11, there is indication that there is no radiation of pain in the upper extremities. There is mention in the note of 03/04/11 that he has radiation across the top of the left shoulder, although this is indicated as being a nonradicular pattern. It should be noted that in the note of
09/23/09, the radiation is described as extending into the hands. There is also documentation in the note of 01/24/11 that the patient has sensory abnormalities in the C5 and C5 dermatomes. It should be noted that there is no upper extremity sensory exam mentioned in the note of 04/13/11, nor is there any sensory exam mentioned in the note of 02/03/11. Therefore, it was difficult to determine definitively that the patient had an absence of radicular findings. Also, there was no information about any prior postoperative facet joint injection. Given the age of the injury and the fact that the surgery was almost 2-1/2 years ago, it seems entirely likely that the patient may have had a facet injection since the surgery; however, the reviewer could not determine this definitively; similarly, the reviewer was unable to obtain information about the extent of postoperative physical therapy. Presumably, the patient had a full course of appropriate physical therapy postoperatively, although it would appear that he may have only received physical therapy in April 2009. There is indication that he had little progress with this; however, given that the guidelines recommend a postsurgical treatment of 24 visits over 16 weeks after graft maturity for fusion, it is possible that if the patient had only four weeks of physical therapy that he might make less than optimal progress. There is also some confusion about the request for medial branch blocks. The request is worded as facet joint levels in the referral form provided. In the voicemail that provided, she appears to have been implying medial branch nerve levels C3-C5 which would be the appropriate medial branch nerve levels for the C4-5 and C5-6 facets. The evaluator was, however, unable to confirm this. Also, it should be noted that the patient appears to have had a previous fusion at the C5-6 level. As is

indicated in the guidelines, diagnostic blocks are not to be performed in patients "who have had a previous fusion procedure at the planned injection level." Finally, even if all of the issues mentioned above had been resolved, there was no opportunity to discuss a potential modification. In light of the above, given the directions provided by the guidelines, rationale for recommendation other than adverse determination for this request cannot be generated at this time. Official Disability Guidelines, 2011 edition.

6-1-11 MD., the claimant has current complaints of low back and neck pain. The patient was injured on xx/xx/xx working for xxbwhere he had worked for 14 years. The patient has had one surgery for this injury. He has had appropriate diagnostic testing and therapeutic procedures up to the present. The patient is 70" in height and weighs 149 pounds. The claimant returns today for follow-up of his chronic neck pain. The request for cervical medial branch blocks to treat the chronic neck pain at C3, C4, and C5 has been declined on second review. The patient states that he is going to move forward with an IRO and he encouraged him to do so. While, he had not seen the second denial, the first denial was based upon the reviewing physician's misunderstanding of the anatomy involved in this particular case. He certainly concurred that the patient has had a C5-C6 fusion, but In order to denervate the C4-C5 level, he need to treat the C5 medial branch which is unaffected by the patient's fusion status. As such, this appears to be a case of misunderstanding by reviewing physician and it is hoped that in IRO he can achieve a successful outcomes that we might better deal with this patient's pain. On examination today, this is a well-developed and well-nourished Caucasian male appearing his stated age and in moderate distress. He is oriented to person, place, time, and situation. Mood and affect are appropriate. Cervical spine alignment is intact, Cervical lordosis is well maintained. Shoulders are level. Cervical motion is moderately restricted in flexion, extension, rotation, and side bending. There is minimal posterior cervical tenderness without spasm. Plan: proceed with cervical medial branch block as we requested and once preauthorization has been determined.

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

BASED ON THE RECORDS PROVIDED, I AGREE THAT THE INJECTION ANESTHETIC AGENT, OTHER PERIPHERAL NERVE OR BRANCH-MEDIAL BRANCH BLOCKS AT C4-5 AND C5-6 TO ADDRESS THE CLAIMANT'S CHRONIC NECK PAIN ARE MEDICALLY NECESSARY. THE FUSION LEVEL IS BELOW WHERE DR. IS ASKING FOR THE INJECTION. THEREFORE, ACCORDING TO ODG THERE IS NO CONFLICT IN PROVIDING THE CLAIMANT WITH THE REQUESTED MEDIAL BRANCH BLOCKS.

ODG-TWC, last update 6-15-11 Occupational Disorders of the Neck and Upper Back – 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 medial branch nerve innervates the facet joint, facet capsular ligaments, the interspinous and supraspinous ligaments, spinous processes and paraspinal muscles. Relief of pain could be due to blockade of nociceptive input from any combination of these. It is suggested that the volume of injectate for diagnostic medial branch blocks be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate) as increased volume may anesthetize these other potential areas of pain generation and confound the ability of the block to accurately diagnose facet pathology. A recent study has recommended that the volume be limited to 0.25 cc.

Epidemiology of involved levels: Using cadaver evidence facet arthrosis most commonly affects the upper cervical levels, and increased with age, and was very rare in patients less than 40 years of age. C4-5 is the most common level followed by C3-4 and C2-3. This study did not attempt to identify number of levels of involvement. (Lee, 2009) Number of levels of involvement: In a randomized controlled trial of therapeutic cervical medial branch blocks it was stated that 48% of patients had 2 joints involved and 52% had three joints involved. (Manchikanti, 2008) These levels were identified by the pain pattern, local or paramedian tenderness over the area of the facet joint, and reproduction of pain to deep pressure. (Manchikanti, 2004) Other prevalence studies from this group also indicated that the majority of patients with cervical involvement were treated at three joints. Target joints were identified as noted above. (Manchikanti,
2004). There are no studies that have actually tested levels of involvement using individual injections for diagnostic verification.
(Lord 1996) (Washington, 2005) (Manchikanti , 2003) (Dreyfuss, 2003) (Falco, 2009) (Nordin, 2009) (Cohen, 2010) See the Low Back Chapter for further references. Complications: See Facet joint therapeutic steroid injections.

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, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy.
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.

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**

☒ **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)**