CLAIMS EVAL

Utilization Review and Peer Review Services

URAC ACCREDITED

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 6-14-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Right cervical facet injection C4-5 under Fluoroscopy 64490, 64491, 72040, 77003

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
American Board of Orthopaedic Surgery-Board Certified

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

- 3-29-11 MRI of the cervical spine.
- 3-29-11 MRI of the thoracic spine.
- 4-12-11 DC., office visit.
- 4-18-11 MD., office visit.
- 5-2-11 UR review performed by DO.
- 5-19-11 UR performed by DO.

PATIENT CLINICAL HISTORY [SUMMARY]:

3-29-11 MRI of the cervical spine shows at C2-C3, C3-C4 and C7-T1 are normal. C4-C5 and C5-C6 there is a broad 1 mm disc protrusion.
3-29-11 MRI of the thoracic spine is normal.
4-12-11 DC., notes the claimant is unable to fulfill her work responsibilities at this time. She will remain off work. Her prognosis is poor.
4-18-11 MD. The claimant is a female who was in her usual state of health. She said she had a work related injury. She injured her neck and shoulders. This happened on xx/xx/xx. It was a work related injury as it happened at work. She said she got some type of injection at the doctor she said at work and then eventually saw Dr. Now she is doing therapy,. She was also placed temporarily in an Aspen collar. She is also getting massage as well as TENS unit. She said it is mainly neck pain, it seems to be more on the right sick: versus the left. It is occasionally down her arm and in her hand she feels pain. There is some weakness down the upper extremities as well as numbness, especially on the right upper extremity. She has also had an MRI of her cervical spine as well as her thoracic spine. The thoracic spine was read' as normal. MRI of the cervical spine did demonstrate at C4/5 and C5/6, there is a broad 1 MM disc protrusion but no central canal or neural foraminal encroachment. Cervical spine range of motion is intact, Spurling causes pain mainly in her neck and shoulders. There is also tenderness, especially on the right side near her facet joints on the right. Straight leg raise is negative. No muscle atrophy. Gait: Normal. Muscle strength is 5/5, Sensation is intact. Reflexes are 2. Plan: recommend a right sided cervical facet injection at C4-C5. she has already had treatment including a cervical collar, oral medication including anti-inflammatories as well as pain medicines as well as therapy. Despite this, she is still having pain. He felt a diagnostic and potentially therapeutic facet injection over the right C4 and C5 could definitely potentially help her.
5-2-11 UR review performed by DO., noted the cervical MRI does not objectively show facet arthropathy or any other type of facet pathology. Cervical facet injections would not be indicated or supported.
5-19-11 UR performed by DO., reported that the request for appeal for right cervical acet injection at C4-C5 under fluoroscopy is non certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
MEDICAL RECORDS REFLECT A CLAIMANT WITH COMPLAINTS OF NECK PAIN. SHE HAS BEEN TREATED WITH MEDICATIONS AND PHYSICAL THERAPY. SHE CONTINUES WITH PAIN. THE MRI OF THE CERVICAL SPINE SHOWS AT C4-C5 AND C5-C6 THERE IS A BROAD 1 MM DISC PROTRUSION. THERE IS NO EVIDENCE OF FACET ARTHROPATHY. PHYSICAL EXAM DOES NOT SHOW FACET MEDIATED PAIN. THEREFORE, THE REQUEST FOR RIGHT CERVICAL FACET INJECTION C4-5 UNDER FLUOROSCOPY 64490, 64491, 72040, 77003 IS NOT MEDICALLY NECESSARY.

ODG-TWC, last update 4-7-11 Occupational Disorders of the Neck and Upper Back – Cervical facet 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)**