

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: MARCH 21, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Cervical Radiofrequency Ablation Bilateral at C4-5, C5-6 (CPT codes: 64426, 64427, 64492, 95937, 77003)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Orthopedic surgery and is engaged in the full time practice of 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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
723.4, 338.4, 722.81	64426		Prosp	1					Upheld
723.4, 338.4, 722.81	64427		Prosp	1					Upheld
723.4, 338.4, 722.81	64492		Prosp	1					Upheld

723.4, 338.4, 722.81	95937		Prosp	1					Upheld
723.4, 338.4, 722.81	77003		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-17 pages

Respondent records- a total of 53 pages of records received to include but not limited to: report 9.14.10; PainCenter notes 12.17.09-1.5.11; report, Hospital 4.2.10-4.9.10; Operative report 4.2.10; Clinical Associates report 2.18.10; note 1.4.10

Respondent records- a total of 53 pages of records received from the URA to include but not limited to: notes 1.6.11, 1.10.11; Medical Management report 1.27.11; Pain Center notes 10.23.09-1.5.11; Associates 2.18.10; M.D. report 1.4.10; Imaging report 2.9.09; x-ray Spine Cervical 2 views 6.8.06

Requestor records- a total of 24 pages of records received to include but not limited to: TDI letter 2.28.11; request for an IRO forms; patient information sheet; Managed Care notes 1.6.11- 1.20.11; Pain Center notes 12.2.10-1.5.11; Medical Management report 1.20.11

PATIENT CLINICAL HISTORY [SUMMARY]:

The records presented for review begin with the January 2011 non-certification of the request for cervical radiofrequency ablation. The injured employee is noted to be the date of injury is noted as xx/xx/xx and there is a chronic regional pain syndrome diagnosis. Median branch blocks reportedly reduced symptoms by 50%. There is also a diagnosis of cervical radiculopathy.

An appeal of this non-certification was made and also not certified. The discussion noted that this request was to address the diagnosis of facet joint pain and that diagnosis had not been objectified. There had been a fusion of the involved cervical vertebra and there was no notation of facet joint disease.

The medical records indicate that this lady was evaluated for a dorsal column stimulator in February 2010. From a psychiatric perspective, this procedure was endorsed.

The progress notes of Dr. noted the original injury being to the right upper extremity, a diagnosis of reflex sympathetic dystrophy was made and in 2007, a cervical fusion was completed. An electrodiagnostic assessment completed in January 2010 was reported as normal. Cervical imaging studies noted a C3-4 defect and ligamentum flavum hypertrophy. The C5-6 and C6-7 fusion was noted.

A September 14, 2010 independent medical examination noted the diagnosis to be post-laminectomy syndrome and segment abnormalities above the fusion. Facet injections were suggested as a treatment option.

Dr. noted in January 2011 that the diagnostic medial branch block gave 50% relief. The assessment was a cervical radiculopathy, post-laminectomy syndrome and chronic regional pain syndrome.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines Criteria for use of cervical facet radiofrequency neurotomy (aka ablation):

1. Treatment requires a diagnosis of facet joint pain. (see below for diagnosis of facet joint pain)
2. Approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function.
3. No more than two joint levels are to be performed at one time
4. If different regions require neural blockade, these should be performed at intervals of not sooner than one week, and preferably 2 weeks for most blocks.
5. There should be evidence of a formal plan of rehabilitation in addition to facet joint therapy.
6. While repeat neurotomies may be required, they should not be required at an interval of less than 6 months from the first procedure. Duration of effect after the first neurotomy should be documented for at least 12 weeks at $\geq 50\%$ relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period.

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, 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

The records reflect that

- A. The appropriate response was not objectified

- B. The response was only 50%
- C. The pain was radicular in nature (as the diagnosis offered was cervical radiculopathy), and there is no documentation of there not being any pain medication taken at home for the requisite four hour period. Therefore, when noting the reported mechanism of injury, the treatment rendered and the relative lack of success of the diagnostic block (50% v. 70%) the criteria for such an intervention is not met.

Accordingly, when applying the standards noted in the Cervical spine Chapter of the ODG (Updated march 2011) this request is not certifiable. The determination is upheld.

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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)