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Notice of Independent Review Decision

Date notice sent to all parties:

October 9, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

BILAT Cervical Facet Injections at C5-C6, C6-C7, CPT 64490 x2 and 64491 x2

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

Board Certified PM&R; Board Certified Pain Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Cover sheet and working documents

Utilization review determination dated 07/26/13, 08/27/13

Office note dated 08/31/12, 09/07/12, 10/03/12, 10/31/12, 01/02/13, 07/16/13, 07/17/13, 08/14/13, 09/18/13

Recheck injury flowsheet dated 07/17/13, 08/14/13

Designated doctor evaluation dated 01/17/13

MRI cervical spine dated 06/25/13

X-rays cervical spine dated 06/25/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. The patient reports that her symptoms came on gradually and became progressively worse. Note dated 09/07/12 indicates that the patient has previously had physical therapy with no significant relief of her symptoms. Patient continues to work full duty. Note dated 10/03/12 indicates that the patient is 2 weeks status post cervical epidural steroid injection on 09/21/12 with only 20% reported therapeutic relief. Designated doctor evaluation dated 01/17/13 indicates that diagnoses are sprain of neck and sprain of shoulder/arm nos. The patient was determined to have reached MMI as of 10/31/12 with 5% whole person impairment. The patient underwent ACDF C6-7 in March 2013. MRI of the cervical spine dated 06/25/13 revealed at C5-6 there are uncovertebral spurs with a traction disc bulge complex measuring 2 mm most accentuated into the left neural foramina; there is moderately severe left neural foraminal narrowing when combined with some facet hypertrophy. The right neural foramen is widely patent. Prior anterior cervical fusion at C6-7 and uncovertebral spurs results in moderate neural foraminal narrowing. Physical examination on 09/18/13 indicates that bilateral upper extremities are intact for strength, reflexes and sensation to light touch. She has decreased right greater than left axial cervical spine rotation secondary to pain. She has negative Tinel's at the right wrist and elbow. Spurling and Hoffman exams are negative bilaterally.

Initial request for bilateral cervical facet injections at C5-6 and C6-7 was non-certified on 07/26/13. The denial was upheld on appeal dated 08/27/13 noting that the patient previously underwent ACDF at C6-7. Official Disability Guidelines considers previous surgical fusion a contraindication for the use of facet injections.

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

Based on the clinical information provided, the request for bilateral cervical facet injections at C5-6, C6-7 CPT 64490 x 2 and 64491 x 2 is not recommended as medically necessary. The patient is status post C6-7 anterior cervical discectomy and fusion performed in March 2013. The Official Disability Guidelines Neck and Upper Back Chapter reports that diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. Therefore, the requested facet injections are not supported as medically necessary.

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Neck and Upper Back Chapter

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 $\geq 70\%$. 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 or unnecessary treatment.