

Notice of Independent Review Decision

August 2, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

C2-3 through C5 Right Cervical Facet Injection Therapy under Fluoroscopy with I.V. Sedation

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. The physician is certified in pain management. The physician is a member of the Texas Medical Board. The physician has a private. The physician has published in medical journals. The physician is a member of his state and national medical societies.

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 medical necessity exists for each of the health care services in dispute.

Upon independent review, the physician finds that the previous adverse determination or determinations should be upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records Received: 27 page fax 07/15/13 Department of Insurance IRO request, 107 pages of documents received via fax on 07/16/13 URA response to disputed services including administrative and medical. 29 pages of documents received via fax on 07/16/13 Provider response to disputed services including administrative and medical. Dates of documents range from xx/xx/xx (DOI) to 07/15/13.

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25 Highland Park Village #100-177 Dallas TX 75205

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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reports being injured on xx/xx/xx secondary to a motor vehicle accident. He complains of neck pain that radiates down into the right arm. The MRI of 06/22/2013 revealed mild degenerative disc disease and mild multilevel unciniate joint osteophyte formation appears similar to the previous exam done on 05/15/2012. EMG done 05/08/2012 reported evidence of cervical radiculopathy/bilateral CTS. Patient had a 2nd ESI on 10/30/2012. A progress note of 12/17/2012 notes that his neck, shoulder and arm pain has been effectively treated with ESI therapy and the patient was wanting to go ahead and do a 3rd ESI. The patient was seen on 04/04/2013, it was noted that his clinical symptoms are consistent with cervical facet syndrome and he was recommend for cervical facet injections therapy. Records also indicate the patient completed 12 visits of PT as of January 2012. That is the recent documentation. Noting that the patient has been diagnosed with cervical radiculopathy with positive EMG findings, and noting that there is no documentation documenting failure of at least 4-6 weeks of conservative care prior to the proposed procedure, the request for C2-3 through C5 Right cervical facet injection therapy with fluoroscopy, IV sedation is not recommended as medically necessary.

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

Noting that the patient has been diagnosed with cervical radiculopathy with positive EMG findings, and noting that there is no documentation documenting failure of at least 4-6 weeks of conservative care prior to the proposed procedure, the request for C2-3 through C5 Right cervical facet injection therapy with fluoroscopy, IV sedation is not recommended as medically necessary and Does not meet EDG criteria.

ODG -TWC

ODG Treatment

Integrated Treatment/Disability Duration Guidelines

Neck and Upper Back (Acute & Chronic)

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. <i>Technique:</i> The described technique of blocking the medial branch nerves in the C3-
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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.

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	<p>11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.</p> <p>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.</p>
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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)