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Notice of Independent Review Decision

DATE OF REVIEW: NOVEMBER 28, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Cervical Facet Block/Interspinous Injections C5-C7 (64490, 64491, 99144, 77003, 20550)

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 Physical Medicine and Rehabilitation 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
728.89			Prosp	1			Xx/xx/xx	xxxxx	Upheld
728.89			Prosp	1			Xx/xx/xx	xxxxx	Upheld
728.89			Prosp	1			Xx/xx/xx	xxxxx	Upheld
728.89			Prosp	1			Xx/xx/xx	xxxxx	Upheld
728.89			Prosp	1			Xx/xx/xx	xxxxx	Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee is a female who reported an injury to her neck and right arm on xx/xx/xx.

The first medical records provided for the compensable injury included an MRI of the cervical spine on March 6, 2014, and the impression, as noted, was:

1. An abnormal study with a ligament injury,
2. There was a nuchal ligament injury with spinous process edema at C6-C7 and C7-T1. No definite avulsion fracture was seen, but there was some edema at the distal spinous processes and nuchal ligament injury, and
3. There was a Grade 1 anterolisthesis at C7-T1. There was no evidence to suggest disruption of the anterior longitudinal ligament, but a CT was recommended to evaluate the facets. Particularly at C7-T1, due to the facet hypertrophy, which was greater on the left.

performed a medical evaluation on April 4, 2014. There were subjective complaints of shoulder pain that radiated down the right arm. The pain was worse when turning the neck. There was numbness in the right arm and hand with muscle weakness in the right arm. Per the provider, the MRI of the shoulder completed on March 6, 2014, reported a partial interstitial tear at the anterior supraspinatus and distal supraspinatus, as well as an infraspinatus and subscapularis tendinopathy with a partial intrasubstance tear at the myotendinous junction. Upon physical examination, there was tenderness in the cervical paraspinous, upper trapezius, and medial scapular muscles. There was painful range of motion of the shoulder. Strength was 5/5, except for 4+/5 in the right upper shoulder. Sensation was intact. Reflexes were 1+ in the bilateral upper extremities. The clinical assessment was neck pain with Grade 1 anterolisthesis at C7 through T1, signs of right cervical radiculopathy, and right shoulder pain with tendinitis. The injured employee had finished twenty-four sessions of physical therapy. The recommendation was for Flexeril and Ultram, a follow-up with an orthopedic surgeon, and electrodiagnostic studies. The injured employee then underwent physical therapy.

At the follow-up on May 28, 2014, there were subjective complaints of neck pain, numbness in the right arm and hand, and right muscle weakness. The injured employee was noted to be taking a Medrol DosePak. Electrodiagnostic studies from April 20, 2014, reported mild carpal tunnel syndrome (CTS) on the right, moderate CTS on the left, and mild sensory deficits in the upper extremities. Upon physical examination, there was cervical spine pain, and tenderness in the paraspinous muscles. The Spurling test was positive. Strength was 5/5, except for 4+/5 with right shoulder abduction. Sensation was intact. The recommendation was to continue the current medications and a cervical epidural steroid injection.

During the evaluation on June 16, 2014, there were subjective complaints of neck pain and headaches. Upon physical examination, there was a decreased active range of motion in the shoulder. The Hawkins test was positive on the right. The cervical spine had a decreased active range of motion. All upper limb reflexes were equal and symmetric. The clinical assessment was cervicalgia and a sprain of the rotator cuff. The recommendation was for a spine specialist.

On June 30, 2014, performed an evaluation. There were subjective complaints of neck pain, arm pain, as well as arm and hand numbness located on the right side. Upon physical examination, there was a decreased active range of motion of the cervical spine with pain. The Spurling test was negative. The right deltoid strength was 5-, and the left deltoid test was 5. Light touch testing was normal. The clinical assessment was cervical spondylosis and whiplash syndrome, a severe interspinous ligament sprain at C6-C7, and rotator cuff syndrome. The recommendation was for Norco and a cervical collar.

During the follow-up on August 25, 2014, there were continued complaints of neck pain. The recommendation was to wear the cervical collar for another month and continue with the Naprosyn, Robaxin, and Hydrocodone.

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 Neck and Upper Back Chapter, updated August 4, 2014, the Guidelines would not support the proposed cervical facet block interspinous injections at C5 through C7. The Guidelines state that cervical facet injections are limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally. The injured employee had subjective complaints of radicular pain, noting radiation from the neck down the right arm with numbness and tingling in the hands. Upon physical examination, there was weakness in the right shoulder. According to the Guidelines, the facet joint pain and symptoms were axial neck pain with no radiation or rarely any radiation past the shoulder. There should be an absence of radicular or neurological findings. The injured employee had radicular symptoms and neurological findings on the electrodiagnostic studies reporting sensory loss in the upper extremities. The following is recommended as outlined in specific sections facet joint diagnostic blocks, facet joint radiofrequency neurotomy, and facet joint therapeutic steroid injections. The cause of this condition is largely unknown, although pain has always generally been thought to be secondary to either a trauma or a degenerative process. Traumatic causes include fracture injuries, dislocation injuries, and whiplash injuries, with the most common cervical levels involved in the latter located at C2-C3 and C5-C6. (Lord 1996) (Barnsley, 2005). The condition has been described as both acute and chronic. It includes symptoms of neck pain, headache, shoulder pain, suprascapular pain, scapular pain, and upper arm pain. (Clemans, 2005)

Symptoms: The most common symptom is unilateral pain that does not radiate past the shoulder. (van Eerd, 2010)

Physical findings: Signs in the cervical region are similar to those found with spinal stenosis, cervical strain, and discogenic pain. Characteristics are generally described as the following:

1. Axial neck pain (either with no radiation or radiation rarely past the shoulders),
2. Tenderness to palpation in the paravertebral areas (over the facet region),
3. Decreased range of motion (particularly with extension and rotation), and
4. The absence of radicular and/or neurologic findings. If radiation to the shoulder has been noted, pathology in this region should be excluded. (Fukui, 1996) (van Eerd, 2010) (Kirpalani, 2008)

This would be recommended prior to a facet neurotomy (a procedure that is considered "under study"). Diagnostic blocks are to be 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 a 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 (a 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 through C7 region (C3-C4, C4-C5, C5-C6, and C6-C7) would be to block the named medial branch nerves (two injections). Authors have described blocking C2-C3 by blocking the third occipital nerve. Another technique of blocking C2-C3 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 a blockade of a 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 diagnose the facet pathology accurately. A recent study recommended that the volume be limited to 0.25 cc.

Epidemiology of the involved levels: Using cadaver evidence, facet arthrosis most commonly affects the upper cervical levels, increased with age, and was very rare in patients less than 40 years of age. C4-C5 was the most common level followed by C3-C4 and C2-C3. This study did not attempt to identify the 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 two 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, as well as the reproduction of pain with 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. The target joints were identified as noted above. (Manchikanti, 2004). There were 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) Please 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: The clinical presentation should be consistent with facet joint pain, signs, and symptoms.

1. One set of diagnostic medial branch blocks would be required with a response of $\geq 70\%$. The pain response should be approximately two hours for Lidocaine,
2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally,
3. There has been documentation of failure of conservative treatment (including home exercise, physical therapy, and NSAIDs) prior to the procedure for at least four to six weeks,
4. No more than two joint levels are to be injected in one session (see above for medial branch block levels),
5. A recommended volume of no more than 0.5 cc of injectate is to be 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 four hours prior to the diagnostic block and for at least four to six hours following the block,
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 visual analog scale (VAS), 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 may be anticipated,
11. It is important to note that diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level, and

It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections, stellate ganglion blocks, 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:

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

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES