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Notice of Independent Review Decision

DATE OF REVIEW: 12/26/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity Left C6-7, C7-8 Cervical facet medial branch blocks.

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

The reviewer is a Medical Doctor who is board certified in orthopedic surgery.

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)

The reviewer agrees with the previous adverse determination regarding the medical necessity Left C6-7, C7-8 Cervical facet medial branch blocks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source):

Records reviewed from

Denial Letter- 11/5/2013

Reconsideration Letter- 12/2/2013

X-Ray Left Shoulder- 6/7/2013

MRI Left Shoulder- 11/2/2012, 4/24/2013

Soap Notes - 6/7/2013

Soap Notes - 7/23/2013

Spine and Pain Management soap notes- 7/30/2013, 9/10/2013, 10/18/2013

Spine and Pain Management Soap Note- 11/25/2013

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was reportedly injured on xx/xx/xx. As of 11/25/13, the patient complained of persistent neck and left shoulder pain, with associated muscle spasms. This was despite multiple medications and prior diagnostic blocks. On exam, there was tenderness to palpation over the left cervical paraspinal soft tissue. Extension, lateral rotation, and flexion was limited due pain. Kemp's sign was positive on the left. The neuro exam was noted to reveal "no focal deficits." The diagnosis included cervical spondylosis. Denial letters noted the lack of positive outcomes of the prior injections and the lack of evidence or absence of cervical radiculopathy.

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

The patient had a previous block at the level of the left C5-7 cervical facets, with only a 15% reported relief overall. Despite that block, there was persistent pain at the level of the neck and left shoulder. The prior cervical facet block did not meet the 70% plus guideline criteria as being considered successful. Therefore repeat blocks of the same area (along with the additional level) as an aggregate cannot be considered as being medically reasonable or necessary as per the referenced guidelines.

Reference: ODG Neck Chapter

Facet joint signs and symptoms, Cervical: Recommended as outlined in specific sections: Facet joint diagnostic blocks; Facet joint radiofrequency neurotomy; & Facet joint therapeutic steroid injections. The cause of this condition is largely unknown although pain is generally thought to be secondary to either trauma or a degenerative process. Traumatic causes include fracture and/or dislocation injuries and whiplash injuries, with the most common cervical levels involved in the latter at C2-3 and C5-6. (Lord 1996) (Barnsley, 2005). The condition has been described as both acute and chronic, and 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 diskogenic pain. Characteristics are generally described as the following: (1) axial neck pain (either with no radiation or 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); & (4) absence of radicular and/or neurologic findings. If radiation to the shoulder is noted pathology in this region should be excluded. (Fukui, 1996) (van Eerd, 2010) (Kirpalani, 2008)

Diagnosis: There is no current proof of a relationship between radiologic findings and pain symptoms. The primary reason for imaging studies is to rule out a neurological etiology of pain symptoms. Diagnosis is recommended with a medial branch block at the level of the presumed pain generator/s. (Kirpalani, 2008)

See Facet joint diagnostic blocks; Facet joint radiofrequency neurotomy; 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.

Medial Branch Blocks

While not recommended, criteria for use of therapeutic intra-articular and medial branch blocks, if used anyway:

Clinical presentation should be consistent with facet joint pain, signs & symptoms.

1. There should be no evidence of radicular pain, spinal stenosis, or previous fusion.

2. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive).
3. When performing therapeutic blocks, no more than 2 levels may be blocked at any one time.
4. If prolonged evidence of effectiveness is obtained after at least one therapeutic block, there should be consideration of performing a radiofrequency neurotomy.
5. There should be evidence of a formal plan of rehabilitation in addition to facet joint injection therapy.
6. No more than one therapeutic intra-articular block is recommended.

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)