

IRO NOTICE OF DECISION – WC



Notice of Independent Review Decision

August 25, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left C3/4, C4/5 facet joint injection

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

American Board of Physical Medicine and Rehabilitation

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

2-3-14 MRI of the cervical spine shows extensive multilevel cervical spondylotic changes. There is straightening of the usual cervical lordosis. There is disc

desiccation throughout. There is significant loss of disc space height at C6-C7 and C5-C6 and to a lesser extent at C4-C5 and C3-C4. There is a combination of disc protrusion and endplate spurring at all levels from C2-C3 through C6-C7. Findings are most marked at C6-C7 level. The ventral and dorsal subarachnoid spaces are completely effaced with diffuse flattening of the ventral cord surface. There is moderate to severe central spinal stenosis at this level with bilateral foraminal stenosis. There are milder findings at the remaining levels. There is at least minimal flattening of the central cord surface at C5-C6 with bilateral foraminal stenosis, minimally greater on the right. There is minimal indentation of the ventral cord surface at the midline at C4-C5. There is bilateral foraminal stenosis. There is also foraminal stenosis without central spinal stenosis at C3-C4 and on the left at C2-C3. There is no obvious intrinsic cord abnormality. A disc protrusion in the upper thoracic spine at the T2-T3 level minimally indents the ventral cord surface.

4-3-14 EMG/NCS of the upper extremities shows moderately severe bilateral sensorimotor carpal tunnel syndrome, the right is more affected than the left. There is no evidence of radiculopathy.

5-12-14 PA, the claimant presents with tingling/numbness that extend to the right arm and hand. Neck pain for 4 months, moderate to severe. Diagnosis: cervicgia, brachial neuritis or radiculitis and carpal tunnel syndrome. Plan: the evaluator recommended night splint, oral medications, carpal tunnel release, and referral for cervical treatment to include possible injections.

6-27-14 MD, the claimant is a male. He suffered an apparently concussion and cervical strain/sprain and other injuries. He has been diagnosed with carpal tunnel syndrome worse on the right than left. He has been treated with physical therapy. No radiation of pain down into the arms. He is working with restrictions. On exam, the claimant is 6'4" weighs 340 lbs. Strength is 5/5, cervical range of motion is unrestricted to the right side and restricted to the left with extension side bending and twisting and extension with rotation. He has tenderness to palpation across the mid cervical paraspinal on the left compared to the right. Sensation is intact. Assessment: Neck pain with spondylosis, status post cervical strain/sprain. He has predominantly axial though there is slight neuropathic component but there is no radiculopathy on EMG/NCS. Recommendations: Physical therapy, C3-C4 and C4-C5 facet joint block, consider radiofrequency ablation thereafter.

7-10-14 MD, UR non certification for facet injections left C3-C4, C4-C5. The guidelines state that the clinical presentation should be consistent with facet joint pain, signs, and symptoms. There is no documentation of any facet tenderness or facet loading. Documentation of failure of lower levels of conservative care, including home exercise or nonsteroidal anti-inflammatory drugs, prior to the procedure for at least four to six weeks was not provided for review. Based on the medical documentation provided for review and the peer-reviewed, evidence-

based guidelines, the request is not medically supported. The request for left C3-C4 and C4-C5 facet joint injection is not certified.

7-28-14 UR non certification for facet injections left C3-C4, C4-C5. Amended 7-31-14.

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

Medical records reflect a claimant with neck pain and tingling/numbness that extends to the right arm and hand. There is a request for left C3-C4 and C4-C5 facet injections. Current treatment guidelines reflect that these injections are limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally. In this case, clinical documentation submitted for review does document a history of signs and symptoms consistent with a cervical radiculopathy. Furthermore, this claimant does not have physical exam findings of facet mediated pain. The MRI of the cervical spine does not show facet arthropathy. At the present time, based upon the medical documentation currently available for review, Official Disability Guidelines (ODG) would not support this specific request to be one of medical necessity. ODG would not support this specific request to be one of medical necessity as specifics are not provided with respect to the type of lower levels of care that have been provided and clinical documentation submitted for review does document a history of signs and symptoms consistent with a cervical radiculopathy. Therefore, the request for Left C 3/4, C4/5 facet joint injection is not reasonable or medically necessary.

ODG 2014 FACET 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.

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)**