



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Notice of Independent Review Decision

Date notice sent to all parties: 03/18/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient bilateral cervical facet block injections at C2-C3, C3-C4, C4-C5, C5-C6, and C6-C7

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Spinal 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)

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

Outpatient bilateral cervical facet block injections at C2-C3, C3-C4, C4-C5, C5-C6, and C6-C7 - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

A lumbar MRI dated 02/15/13 revealed no evidence of acute lumbar spine abnormality. There were mild degenerative changes with degenerative disc

disease at L4-L5 and L5-S1. There were facet hypertrophic changes at these levels resulting in mild bilateral neuroforaminal narrowing without definite exiting nerve root compression. The patient was injured on xx/xx/xx when the pipe wrench slipped from the valve, causing him to lose his footing and fall back. The patient presented to the emergency room on xx/xx/xx. He complained of non-traumatic headache pain in the occiput with a "burning" lump and swelling to the back of his head since the day before. He denied dizziness and acute changes in vision. He also denied LOC. He was alert and oriented times three. His ENT exam was normal. He was discharged with the diagnosis of a tension headache and acute myofascial strain. Hydrocodone/APAP was prescribed. Cervical x-rays dated 08/02/14 revealed mild degenerative findings and straightening of the normal cervical lordotic curve versus patient positioning or splinting. The remainder of the examination was normal. examined the patient on 08/18/14. He had neck pain and was on Hydrocodone and Gabapentin with relief. He had a burning sensation to the neck area. He had a PMH for high cholesterol, high blood pressure, and he was a former smoker. He was also using Cyclobenzaprine. He reported numbness and tingling, but denied headaches. He was 69 inches tall and weighed 233 pounds. Neurological examination revealed bilateral upper extremity reflexes at 0/4. The musculoskeletal examination was deferred for unclear reasons. The diagnoses were displacement of the cervical IVD without myelopathy, prolapsed cervical intervertebral disc, cervical root lesions, cervical radiculopathy, and myalgia and myositis. Therapy was recommended, as was an EMG/NCV study. An EMG/NCV study of the bilateral upper extremities dated 08/20/14 revealed evidence of a left C6 and C7 radiculopathy. A cervical MRI was obtained on 08/28/14 and revealed no significant posterior disc herniations and moderate facet joint osteoarthritic changes noted on the left side at C2-C4 with mild neural foraminal narrowing. There was also mild to moderate narrowing of the neural foramina at C5-C6 due to uncovertebral joint osteoarthritic changes. There was also mild narrowing of the neural foramina at C4-C5 and C6-C7. On 09/08/14, reviewed the MRI. He noted therapy was helping his pain. The musculoskeletal examination was again deferred and the bilateral upper and lower extremity strength and reflexes were normal. Sensory examination was also normal. Trigger point injections were recommended and it was noted the patient did not want surgery. Trigger point injections were performed on 09/18/14. The carrier filed a DWC PLN-11 on 09/23/14 noting the work related incident was limited to a cervical sprain/strain. examined the patient on 11/03/14. He was injured on August 1 (year not specified) when he was trying to unscrew a heavy lug with a wrench when it suddenly gave way and he was flung backwards. He snapped his neck and continued to work, but that night he had increased left paracervical area pain. He also had occasional numbness and tingling in the left arm. noted this was in the C8 distribution and he had not been able to work. He had undergone four weeks of therapy, trigger point injections, and a cervical MRI. He was on Naproxen and Flexeril. Motor examination and strength was normal in the bilateral upper extremities. There was some mild hypalgesia and hypoesthesia in the left C7 and C8 distributions however, interosseous function was normal. The reflexes were extremely poorly elicited and were symmetrically so. He had normal cervical

range of motion, but it was painful. Tinel's was negative and the MRI and EMG/NCV study were reviewed. felt the patient seemed to be suffering from myofascial disease with nerve irritation in the paraspinal musculature. He noted it was also possible he had some mild radiculopathy and neck pain related to whiplash and facet disease that might have been preexisting, but was aggravated following his injury. recommended continued therapy and cervical flexion and extension films were recommended. He was given an analgesic cream. On 11/04/14, the carrier filed another DWC PLN-11 noting they disputed entitlement of treatment for cervical disc displacement and/or cervical root lesion. The patient attended therapy on 11/25/14. On 12/02/14, reevaluated the patient. He was doing fine and recovering nicely and he had had returned to work. His family physician had released him to full duty. He however had continued with cervical pain syndrome on the left. His lumbar pain had recovered. He had undergone nine sessions of work hardening and was ready to work. He did not have any weakness, numbness, or tingling in the arms or legs, according. Sensation was normal and motor function was normal in all of the extremities. He could flex and extend his back well and the lumbar and cervical MRIs were reviewed. noted the patient had no surgical pathology, but had constant cervical pain as a consequence of facet disease along with the work related injury. He was returned to full, unrestricted duty and cervical facet joint blocks were recommended. The patient returned on 01/13/15. He had cervical pain bilaterally and constantly, more so on the left than the right and into the crook of his neck. He was working. Examination was unchanged. He had paracervical bilateral paraspinal spasms and tenderness over the mid to lower cervical spine. felt the patient had cervical facet arthropathy at C2-C3 through C6-C7 bilaterally with some foraminal stenosis most likely contributing towards the nerve of Luschka irritation and a cervical radiculopathy. The bilateral facet joint injections were again recommended. A TENS unit was also prescribed, as well as a soft cervical collar. On 01/22/15, provided a preauthorization request for the cervical facet joint injections. provided an adverse determination notice on 01/27/15 for the requested bilateral cervical facet block injections. On 01/27/15, provided an appeal/preauthorization request for the cervical facet joint injections. provided another notice of adverse determination for the requested bilateral cervical facet block injections at C2-C3, C3-C4, C4-C5, C5-C6, and C6-C7 levels. examined the patient on 02/05/15. He was noted to have chronic neck pain and he had been seen by neurosurgery with no new recommendations. He would be referred to "pain". He had tenderness at C5 and C6. The assessment was myalgia. Naproxen was prescribed.

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

had requested cervical facet block injections in almost the entire cervical spine bilaterally. The physical examinations do not show any focal findings, other than diffuse tenderness. There are no facet localizing signs. In fact, in the 12/02/14, it was noted the patient's PCP had returned him to full work duty. He had left sided cervical pain only and had no weakness, numbness, or tingling. Furthermore, sensation and motor function of the bilateral upper and lower extremities was

normal. The ODG Treatment Guidelines, Neck and Upper Back Chapter, note in regard to facet injections, the clinical presentation should be consistent with facet joint pain and symptoms. The criteria include one set of diagnostic medial branch blocks with a response of greater than 70%. The pain response was noted to be approximately two hours for Lidocaine. The ODG further notes the injections should be limited to patients with cervical pain that is non-radicular and the injections are to be performed at no more than two levels bilaterally. The ODG also notes there should be documentation of failure of conservative treatment, including physical therapy, home exercises, and non-steroidal anti-inflammatories, prior to the procedure for at least four to six weeks. Therefore, due to the lack of positive, objective findings and the excessive cervical levels being requested, his request does not meet the criteria of the ODG. Therefore, the requested outpatient bilateral cervical facet block injections at C2-C3, C3-C4, C4-C5, C5-C6, and C6-C7 are not medically necessary or appropriate and the previous adverse determinations should be upheld at this time.

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)