

# Parker Healthcare Management Organization, Inc.

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**DATE OF REVIEW:** APRIL 28, 2015

**IRO CASE #:**

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Medical necessity of proposed bilateral C 4/5, C 6/7 facet joint injection  
(64490, 64491, 77003)

## **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
727.61	64490		Prosp	1			Xx/xx/xx	V10000105835	Upheld
727.61	64491		Prosp	1			Xx/xx/xx	V10000105835	Upheld
727.61	77003		Prosp	1			Xx/xx/xx	V10000105835	Upheld

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

An MRI scan of the cervical spine was performed on May 15, 2013, and the impression, as reported by , was:

1. Status post C5-C6 fusion,
2. 2mm retrolisthesis of C4 on C5 with associated C4-C5 endplate edema,
3. Multilevel endplate spurring with also osteophytes and disc bulges resulting in narrowing of the anterior CSF space at C3-C4, narrowing of the anterior and posterior CSF at C4-C5 and C6-C7, but without cord compression or cord signal abnormality, and
4. Multilevel neural foraminal narrowing.

An MRI scan of the right shoulder was also performed on May 15, 2013, and the

impression, as reported was:

1. Complete tear of the supraspinatus tendon with medial tendon retraction,
2. Partial tear of the infraspinatus and subscapularis tendons,
3. Anterior superior glenoid labral anchor with slight heterogeneity of the labrum in this area, but the labrum appeared intact and without definite tear,
4. Moderate joint effusion,
5. Subacromial/subdeltoid fluid, likely due to extension of the joint effusion secondary to the tear of the supraspinatus tendon, and
6. Moderate osteoarthritis of the right acromioclavicular joint with findings suggestive of prior acromioplasty.

evaluated the injured employee on October 25, 2013. The medical note reports the injured employee was pulling a large object from the back of the truck and it got hung. The injured employee's hand slipped off and he fell backwards, landing with all of his weight on his right elbow, resulting in an injury to the right neck, right shoulder, and right elbow. The physical examination of the cervical spine reported that range of motion had remained the same. The muscle spasms along the paraspinal muscles had remained the same. Compression test was negative, Spurling's test negative. Deep tendon reflexes, sensation, and motor strength were normal.

The physical examination of the right shoulder demonstrated tenderness had remained the same. Range of motion showed flexion was 140°, abduction 120°, internal rotation 80°, and external rotation 80°. There was weakness in the supraspinatus, infraspinatus, teres minor, and subscapularis muscles. The examination of the right elbow noted the bruising had resolved. There was full range of motion in flexion. Extension was full. The tenderness in the olecranon progress had remained the same. Supination and pronation had returned to normal. The assessment was unspecified derangement of joint, shoulder region; bilateral displacement of cervical intervertebral disc without myelopathy; and right elbow pushing injury. The treatment recommendations were to continue physical therapy; Naprosyn, Robaxin, and Neurontin were prescribed; continue light duty; follow up with orthopedics; and follow up as directed.

It was noted the injured employee underwent physical therapy at .

evaluated the injured employee on November 25, 2013, for neck and arm pain. The injured employee reported the right arm got weak when trying to lift it and carry things. The injured employee had a history of a C5-C6 fusion in 1998. The physical examination of the cervical spine demonstrated alignment was neutral. There was tenderness to palpation of the levator scapulae, trapezius, and scalene muscles on the right. The occipital area was nontender. The spinous processes were nontender. Cervical range of motion was painful and restricted about 25% of normal in all planes. Spurling's was positive on the right and negative on the left. Deep tendon reflexes were normal, except the right triceps was hyporeflexive. Light touch was abnormal at the C7 and C8 dermatomes. The assessment was right-sided cervical radicular symptom without any motor deficits. The treatment recommendation was Mobic; recommend transforaminal epidural steroid injection, probably at right C6-C7 or C4-C5, and would review the films before ordering injection; and the injured employee would follow up following the injection.

The injured employee underwent a cervical epidural steroid injection at C4-C5 and C6-C7 under fluoroscopy guidance by on December 18, 2013. On follow-up with on January 29, 2014, the injured employee reported about 80% relief for the first three weeks after the injection and now the pain was coming back. The injured employee reported some numbness in the right arm and it got weak. He denied any balance issues. The physical examination did not demonstrate any changes from previous exams. The treatment recommendations on this date were a Medrol Dosepak and Flexeril were prescribed; and

the injured employee would follow up in two weeks and if no better, may repeat injection.

On re-evaluation on February 12, 2014, at , the injured employee reported he was still having a lot of pain when turning the neck to the right, was also feeling some numbness in the right arm, and had been off work since April. The physical examination of the cervical spine demonstrated 25% decrease in range of motion in all planes. Spurling's was positive on the right and negative on the left. Deep tendon reflexes were normal in the biceps; right triceps was hyporeflexive. There was abnormal sensation to light touch on the right in the C7 and C8 dermatomes. The treatment recommendation was to recommend a second cervical epidural steroid injection. The injured employee was to follow up after the injection.

On follow-up at on January 8, 2015, the injured employee was following up for neck pain and headaches and bilateral arm pain. The injured employee reported symptoms were worse since previous visit and continued to use tramadol for pain. The physical examination demonstrated 5/5 strength in the bilateral upper extremities with no hyperreflexia and no clonus. The injured employee was not using any assistive aids. There were paresthesias into the shoulders bilaterally. Cervical tension signs were positive in the left arm with radiation to the left shoulder. The assessment was C5-C6 previous fusion; cervical radicular syndrome; and C4-C5 and C6- C7 cervical spondylosis. The treatment recommendations were to continue tramadol and Zanaflex and recommend MRI scan of the cervical spine.

An MRI scan of the cervical spine was performed on January 29, 2015, and the impression, as reported by , was:

1. Osteophyte formation, bulging retrolisthesis seen at C4 on C5 with spinal stenosis of 9.6 mm at C4-C5, the expected canal measurement was greater than 10 mm,
2. At C5-C6, there was surgical change with no disc herniation, stenosis, or canal compromise, and
3. There was an osteophyte and disc extrusion complex at C6-C7 narrowing the ventral subarachnoid space, but no central stenosis.

re-evaluated the injured employee on March 12, 2015. The injured employee had a chief complaint of neck and arm pain. The injured employee reported continued symptoms. The physical examination demonstrated 5/5 strength in the bilateral upper and lower extremities with no hyperreflexia, no clonus, and no assistive aids. There were paresthesias in the shoulders bilaterally. Cervical tension signs were positive in the right arm with radiation into the right shoulder upon right-sided neck flexion. Treatment recommendations were facet injection at C4-C5 and C6-C7 bilaterally, hydrocodone was refilled, and follow up after injection. The injured employee may be a potential candidate for C4-C5 and C6-C7 anterior cervical fusion revision.

A Peer Review was performed by on April 1, 2015. reported the injured employee had radiculopathy on examination and MRI scan, which was a contraindication in doing facet procedures per the Official Disability Guidelines. The medical doctor also felt the individual may need a fusion, which was another contraindication to this procedure. Therefore, the request for the bilateral C4-C5 and C6-C7 facet joint injection would not be medically necessary.

**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.**

As noted in the Division-mandated Official Disability Guidelines Neck and Upper Back Chapter (updated November 18, 2014), facet injections must be consistent with facet joint pain, signs, and symptoms, which includes axial neck pain either with no radiation or rarely past the shoulders; tenderness to palpation in the paravertebral areas or over the facet region; decreased range of motion, particularly with extension and rotation; and absence of radicular or other neurological findings. There also must be a diagnostic set of medial branch blocks. The required response is greater than or equal to 70%, limited to individuals with cervical pain that is nonradicular at no more than two levels bilaterally, and documentation of failure of conservative treatment. The guidelines also indicate diagnostic facet blocks should not be performed in individuals in whom a surgical procedure is anticipated. I would have to uphold the previous noncertification, as the documentation provided for review does not meet the requirements as outlined in the guidelines.

The most recent physical examination provided for review noted there were paresthesias into the shoulders bilaterally. The cervical tension signs were positive on the right arm with radiation to the right shoulder upon right neck flexion, but there was no specific documentation of tenderness over the requested facet regions. The physical findings document the injured employee has demonstrated radicular findings. Additionally, it was not clear, based upon the documentation, what recent conservative care the injured employee has undergone, other than oral medications. There was no documentation the injured employee has undergone any medial branch blocks. The medical documentation reported the injured employee may be a candidate for a two-level fusion. Based upon the medical documentation provided for review, uphold the non-certification of the proposed bilateral C4-C5 and C6-C7 facet joint injections.

**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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)