Specialty Independent Review Organization

Date notice sent to all parties: 1/29/2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: The item in dispute is the prospective medical necessity of cervical facet blocks C2/C3, C3/C4 level medial branch on the right x1.

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 Anesthesiology.

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 prospective medical necessity of cervical facet blocks C2/C3, C3/C4 level medial branch on the right x1.

Records reviewed from The Back and Neck Clinics: All records are duplicates from above.

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

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XX year old XX complaining of cervical pain from an injury on XXXX. An MRI on XXXX did not show any acute herniated disc but multiple spondylotic changes. Degenerative disc disease, mild spondylosis most pronounced C4-C7, moderate to mild left foraminal stenosis C4/C5 from spondylotic complex were noted. The patient has a needle phobia. The injection is to be followed by physical therapy. The exam on XXXX showed decreased ROM on cervical flexion, extension and rotation, pain in the right C2/C3, C3/4 cervical facets.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Per ODG, facet joint diagnostic blocks are limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally provided that there is a documentation of failure of conservative treatment for at least 4 to 6 weeks. The patient complained of neck pain which was constant and made worse by turning his head. It was noted that the patient has had physical therapy, however, there were no actual therapy records submitted for review to validate failure, completion and its duration prior to the consideration of this request. The patient's objective response to determining failure of conservative treatment (including home exercise, PT, and NSAIDs) could not be established. Per evidence-based guidelines, and the records submitted, this request is non-certified. Therefore, the request is not medically necessary.

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition
Neck and Upper Back Chapter (updated 10/12/17)
Facet joint diagnostic blocks, subheading
Recommended prior to facet neurotomy (a procedure that is considered "under study").
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 50-70 percent. 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 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.
Facet joint pain, signs & symptoms, subheading
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 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 discogenic 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); and (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 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.

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)**