AccuReview
An Independent Review Organization
569 TM West Parkway
West, TX 76691
Phone (254) 640-1738
Fax (888) 492-8305

February 12, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
A1 C5, C6 and C7 cervical selective nerve root block under fluoroscopy and anesthesia between XXXX and XXXX.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board certified in Anesthesiology with over 15 years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
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]:
XXXX: Cervical Spine 3 views dictated by XXXX. Conclusion: Trace degenerative changes in the mid cervical spine.

XXXX: MRI Cervical Spine without Contrast dictated by XXXX Impression: 1. Multilevel degenerative disease as detailed above is worst at the C5-C6 level. At this level, a small focal disc protrusion superimposed upon disc osteophyte complex abuts the anterior spinal cord and causes moderate canal stenosis. There is also severe right neural foramen narrowing at this level from prominent right lateralized facet and uncovertebral joint spur. 2. No cord edema or frank compression.

XXXX: Office Visit dictated by XXXX. CC: right-sided neck, shoulder, pain in the right arm after a XXXX at work XXXX. DX: C5-6, C4-5 HNP, cervical radiation. Disposition: Bilateral C5 and C6 selective nerve root block. Assessment: Right-sided cervical radiculopathy from acute on chronic herniated nucleus pulposus in the setting of a disc osteophyte complex after a work-related injury. Mixed picture radiculopathy with clinical right C7 sensory but weakness with XX shoulder abduction grip strength and hand intrinsies.

XXXX: Upper Extremities EMG/NCV dictated by XXXX. Impression: This NCV/EMG study of upper extremities showed moderate active denervation changes affecting bilateral C6>C7 nerve root territory more on the right. NCV part showed mild conduction velocity slowing seen in bilateral median nerves across the wrist. Findings do not fully meet electrodiagnostic criteria for the compression syndrome.

XXXX: Office Visit dictated by XXXX. CC: neck pain. PE: Cervical Exam: posture: forward flexion, tenderness to palpation to the right, radiates down right with facet tenderness right and positive Spurling test.

XXXX: X-ray cervical Complete w/Flexion and Extension dictated by XXXX. Impression: 1. No acute finding is seen. Soft tissue calcifications noted posteriorly. There is mild narrowing of the interspace at 5 6 and 6 7 particularly on flexion views. There is a marked limitation of extension from the neutral position.

XXXX: Office Visit dictated by XXXX. CC: right-sided neck pain. The claimant is being sent for right C5, C6 and C7 selective nerve root blocks. Will see XX back again in 2 weeks thereafter. XX opted for spinal injections.

XXXX: Initial Consultation dictated by XXXX, ANP-HC. CC: right neck pain, right upper extremity pain. HPI: XX year-old-XX who had work injury on XXXX after XXXX at work and is in the bilateral occipital regions, bilateral posterior neck, bilateral medial scapulae. Pain is described as aching, burning and numbness. PT has been ineffective and activity modification and medications improved symptoms. OT: the claimant has not been back to work since XX accident. Current Medications: Tylenol #3, Vitamin D3, Aspirin Ec, Brilinta, Lorazepam, Metoprolol, Montelukast, Pantoprazole, and Pravastatin. PE: Cervical Spine: point of maximum tenderness: right lower cervical paravertebral and right trapezius. ROM limited in flexion by pain and right rotation by pain. Impression: Cervical Facet Arthropathy Levels, Moderate neuroforaminal stenosis is noted C4-5, Cervical disc disorder with radiculopathy Right C6-C7, cervical degenerative disc disease, Spinal Stenosis. Recommendations: The claimant has suffered from more than 2 weeks of radicular symptoms without specific identifiable spinal nerve level etiology. Cervical Selective Nerve Root Block/Transforaminal ESI Right C5, C6 and C7.

XXXX: UR performed by XXXX. Reason for denial: The requested selective blocks are not warranted. The evidence-based guidelines recommend diagnostic epidural steroid injections in specific cases, including when there is evidence of multi-level nerve root compression or when imaging studies are inconclusive. In this case, MRI of the cervical spine does not appear to be inconclusive, and while multi-level changes were noted, there was no evidence of multi-level nerve root compression. Additionally, the level of sedation requested is not congruent with the guideline recommendations. With the above in mind, the request for 1 C5, C6 and C7 cervical selective nerve root block under fluoroscopy and anesthesia is non-certified.

XXXX: UR performed by XXXX. Reason for denial: Non-certification was appropriate. The claimant does not meet the criteria for transforaminal epidural steroid injections. The guidelines do not recommend more than two levels of injection or sedation during procedure. The provider has not submitted additional documentation that would warrant deviation from the guidelines criteria. Therefore, 1 C5, C6 and C7 cervical selective nerve root block under fluoroscopy and anesthesia in non-certified.

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

Based on the records submitted and peer-reviewed guidelines, the claimant does not meet the criteria for transforaminal epidural steroid injections. The guidelines do not recommend more than two levels of injection or sedation during cervical procedures. The provider has not submitted additional documentation that would warrant deviation from the guidelines. Therefore, the request for A1 C5, C6 and C7 cervical selective nerve root block under fluoroscopy and anesthesia between XXXX and XXXX is not medically necessary; non-certified.

Per ODG:

Facet joint diagnostic blocks	**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 ≥ 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)**