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IRO CASE #: XX
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Radiofrequency neurolysis/ablation (RFA) medial branch of the dorsal ramus C2-C3, C3-C4 levels of the left side x1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
American Board of Physical Medicine & Rehabilitation
American Board of Pain Medicine

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

Official Disability Guidelines Neck and Upper Back chapter, Facet Joint radiofrequency neurotomy subheading criteria was used for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XX who was injured on XX. XX was XX landed on XX left side of the neck and shoulder. XX experienced left shoulder and neck pain since then.

On XX, the patient underwent a magnetic resonance imaging (MRI) of the cervical spine for a cervical sprain. The study revealed at C3-C4 a broad-based posterior disc protrusion with mild bilateral neural foraminal narrowing. At C4-C5, a broad-based posterior disc protrusion with mild right neural foraminal narrowing was present. At C5-C6, a broad-based posterior disc protrusion was noted. At C6-C7, a broad-based posterior disc protrusion with moderate-severe bilateral neural foraminal narrowing and borderline mild central canal stenosis was seen. At C7-T1, a broad-based posterior disc protrusion was seen. Multilevel cervical facet arthrosis was noted at C3-C4, C4-C5, C5-C6, C6-C7 and C7-T1 levels.

On XX, the patient was recommended PT two to three times a week for four to six weeks for neck pain at XX during a PT evaluation.

On XX, XX, M.D., saw the patient for neck pain radiating to the left upper extremity. Past surgical history was notable for left ACL surgery, right carpal tunnel surgery and elbow release surgery. The current medications included XX, XX and XX. The exam revealed facet tenderness in the C4-C7 levels; pain with bilateral lateral rotation, left greater than the right side; positive Spurling's on the left with radiation to the proximal arm; left upper extremity strength 4/5. The left shoulder exam revealed a normal range of motion (ROM) and mild tenderness. XX prescribed XX, XX and XX and referred the patent to PT.

From XX, through XX, the patient attended 12 PT sessions for neck pain at XX.

On XX, XX, M.D., noted the patient experienced no improvement in neck pain despite PT. On the exam, the left biceps and brachioradialis reflexes were slightly diminished on the left. The Tinel's sign was positive on the left side. The sensation was decreased in the left C6 distribution. PT was continued and electromyography/nerve conduction velocity (EMG/NCV) of the upper extremities was recommended.

On XX and XX, XX, NP noted the patient did not find much relief to the neck pain. XX and XX were started, PT was continued, and the patient was referred to XX.

On XX, XX, M.D., noted the patient experienced persistent headaches and neck pain radiating to the left upper extremity. The pain level was 4-6/10. On neck exam, decreased flexion, extension, left and right rotation; facet tenderness on the left cervical region; facet pain at C2-C3 and C3-C4 levels; and axial loading of the cervical spine were noted. The diagnosis was a cervical sprain. XX planned of cervical facet block of medial branch of the dorsal ramus of C2-C3 and C3-C4 levels on the left; and if successful, radiofrequency ablation (RFA) in future with PT.

From XX, through XX, XX noted the patient continued to experience neck pain radiating to the left upper extremity. The treatment recommendations included cervical facet block, continued PT, chronic pain program, a functional capacity evaluation (FCE) and a psychological evaluation. On XX, XX noted the patient was able to stand for less than 30 minutes, sit for less than 30 minutes, and walk for more than 30 minutes. The worst pain level was 4-6/10. The current pain level was 4-6/10. There was no change in the review of systems and exam since the most recent visit.

On XX, XX performed medial branch block (MBB) at the left C2-C3 and C3-C4 levels.

On XX, XX noted the patient experienced more than 90% pain relief after the MBB, which lasted for 2-3 days. The pain medications were decreased as the patient had less stress and pain. However, the pain had returned and XX wanted another injection. The worst pain level was 7-9/10; current pain level was 0-3/10. The patient was able to stand for more than 30 minutes, sit for more than 30 minutes, and walk for more than 30 minutes. XX was able to sleep better. The review of systems and physical exam did not show any significant changes since the last office visit. XX recommended a left C2-C3 and C3-C4 RFA and XX.

Per utilization review dated XX, the request for radiofrequency neurolysis/ablation (RFA), medial branch of dorsal ramus left C2-C3 was denied. Rationale: *"Based on the clinical information submitted for this review and using the evidence-based, peer- reviewed guidelines referenced, this request is non-certified. Approval of facet joint radiofrequency neurotomy depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function. The patient underwent cervical medial branch block at the left C2-C3 and C3-C4 medial branch levels on XX. However, the duration and percentage of pain relief were not documented, as there was no follow-up note to this procedure included for review. Evidence of ongoing rehabilitation plan was also not included in this request. A comprehensive evaluation of the patient's condition, the efficacy of the diagnostic block and continuing formal treatment plan should be considered to establish the necessity for the request. Thus the request is not supported at this time."*

On XX, XX noted the patient experienced neck pain and headaches rated at 4-6/10. At worst, the pain level was 7-9/10. Cervical RFA was recommended.

On XX, appeal for cervical RFA was documented by XX.

Per a reconsideration dated XX, the denial for RFA medial branch of dorsal ramus left C2-C3 was upheld. Rationale: "*The request cannot be supported based on the documentation provided. The request was previously noncertified on XX which noted radiofrequency neurotomy was under study and treatment required diagnosis of facet joint pain using medial branch block, and there was lack of an objective adequate diagnostic block and lack of a formal plan of*

rehabilitation. Additional documentation includes the evaluation of XX The request, however, remains noncertified. Although the physician notes that the claimant was overall improved by 90 percent with ability to sit, stand, and walk longer, sleep better, and had a decrease in use of pain medication, the additional examination notes no changes in review of systems, no changes in physical examination findings, and no documented quantity of medication reduction post-injection. Pain scores appear unchanged from the pre-injection progress notes. Without objective documentation to support the physician's recorded 90 percent pain improvement, a true diagnostic medial branch block cannot be supported in accordance with the guidelines, again noting radiofrequency ablation remains under study as there is lack of documented benefit of the procedure. The appeal request for radiofrequency neurolysis/ablation of the medial branch of the dorsal ramus on the left at C2-C3 is not certified."

On XX, XX noted the patient continued to experience headaches and neck pain rated at 4-6/10. The patient experienced pain relief with medications, ice pack and lying flat. No significant changes were noted in the physical exam since the last visit. The diagnosis was cervical spine sprain. Cervical RFA was denied by the reviewer. Follow-up was recommended in a month.

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

Per the ODG criteria:

1. Treatment requires a diagnosis of facet joint pain. Yes, the patient underwent diagnostic MBB left C23 and C34 joints.
2. Approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function.
    a. Yes, the note dated, XX, states that the patient's pain improved 90% after diagnostic Left MBB. VAS scores are documented at worst 7-9/10 down to 0-3/10. It is documented that XX pain relief duration was 2-3 days. Furthermore, improvement in function is noted by the ability to sit, stand, and walk longer, sleep better, and a decrease in use of pain medication.
    b. Please note that the guidelines do not require a decrease in medication after MBB for RFA.
3. No more than two joint levels are to be performed at one time.
    a. Yes, no more than 2 levels are being requested.
4. If different regions require neural blockade, these should be performed at intervals of not sooner than one week and preferably 2 weeks for most blocks.
    a. N/A at this time
5. There should be evidence of a formal plan of rehabilitation in addition to facet joint therapy.
    a. Yes, per theXX, XX is included in the Plan.
6. While repeat neurotomies may be required, they should not be required at an interval of less than 6 months from the first procedure. Duration of effect after the first neurotomy should be documented for at least 12 weeks at >50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year period.
    a. N/A at this time.

The patient has met the above ODG criteria for proceeding with facet joint radiofrequency neurotomy. Thus, the requested procedure Radiofrequency neurolysis/ablation (RFA) medial branch of the dorsal ramus C2-C3 and C3-C4 levels of the left side x1 is supported at this time.

Medical documentation **supports** the medical necessity of the health care services in dispute.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES