Parker Healthcare Management Organization, Inc.
3719 N. Beltline Rd Irving, TX 75038
972.906.0603 972.906.0615 (fax)
IRO Cert XXXX

DATE OF REVIEW: JULY 16, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Medical necessity of proposed Right C5-C6, C6-C7 Radiofrequency (64633, 64634)

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:

XX Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX who was injured on XX, while on XX, causing the claimant to XX for XX. The claimant was diagnosed with a cervical sprain. Following the injury, subjective complaints of cervical and left shoulder pain were noted. Past medical history included cervical C3 disc fracture in XX and the past surgical history included a rotator cuff repair in XX. A body mass index of 36.8 was noted. An MRI of the cervical spine on XX, reported a large left-sided disc extrusion/protrusion and herniation at C5-C6, extending above into the level of the C6 interspace, and cervical spondylosis was noted at C3-C4, C4-C5, and C6-C7. Cervical epidural XX injections were performed on XX, and XX, and XX of pain relief was reported. A recent evaluation noted the claimant reported tenderness to palpation over the right facets with facet loading and pain radiating into the right trapezius muscle. No sensory or motor deficit was noted in the bilateral upper extremities. Reflexes and strength were normal. It was noted that the claimant underwent right-sided C5-C6 and C6-C7 medial branch blocks on XX. On evaluation of XX, the claimant reported 90% improvement in symptoms for the first day with still 80% improved pain. A subjective complaint of chronic pain in the left shoulder was reported as well, which was unchanged since the injury. There was prior decompression surgery of the shoulder; however, there were new partial tears of the biceps and rotator cuff tendons on MRI. The physician requested to proceed with radiofrequency ablation at C5-C6 and C6-C7 to be performed under sedation.

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.

RATIONALE: The request was previously noncertified on XX, due to lack of medical necessity, noting the prior diagnostic medial branch block was performed with total intravenous anesthesia, which could skew results and as there was no evidence of a formal plan of rehabilitation in addition to the requested facet joint therapy. No additional documentation was submitted. The request remains noncertified. The guidelines state radiofrequency neurotomy is under study as there is conflicting evidence supporting benefit and efficacy of the procedure. The claimant is noted to have had medial branch blocks performed under total intravenous anesthesia and reported an initial 90% improvement and 80% improvement when evaluated in XX. However, this is not supported objectively with decreased pain scores, decreased medication requirement, or improved function, in accordance with the guidelines to support a diagnostic block. The guidelines state intravenous sedation may be grounds to negate the results of the diagnostic block and X be documented pain relief with decreased pain scores, emphasizing the importance of recording the maximum pain relief and maximum duration of pain, keeping medication use activity logs to support the subjective reports of better pain control. Additionally, there is no evidence of a formal plan of additional evidence-based rehabilitation in addition to the requested facet joint therapy which is recommended by the guidelines. Therefore, medical necessity has not been established for right C5-C6 and C6-C7 radiofrequency (64633, 64634).

Official Disability Guidelines
ODG Treatment
Integrated Treatment/Disability Duration Guidelines
Neck and Upper Back (Acute and Chronic)
(updated XX)
Facet joint radiofrequency neurotomy
Under study. Conflicting evidence, which is primarily observational, is available as to the efficacy of this procedure, and approval of treatment should be made on a case-by-case basis.
See also Cervicogenic headache, facet joint neurotomy. See the Low Back Chapter for further references.
Criteria for use of cervical facet radiofrequency neurotomy:
1. Treatment requires a diagnosis of facet joint pain. See Facet joint diagnostic blocks.
2. Approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function.
3. No more than two joint levels are to be performed at one time (See Facet joint diagnostic blocks).
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.
5. There should be evidence of a formal plan of rehabilitation in addition to facet joint therapy.
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's period.
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.

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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
- ☐ AHRQ- 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
- 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)