

True Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW: March 4, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Diagnostic Bilateral Cervical Facet Blocks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

Subspecialty Board Certified in Electrodiagnostic Medicine

Residency Training PMR and ORTHOPAEDIC SURGERY

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 11/7/07, 11/13/07, 12/28/07, 1/8/08

Network 10/9/98

Op Report 9/25/97

Letter from Dr. 12/28/04

CT Scan 12/18/96

Radiology Reports 2/17/99, 7/23/99, 10/5/07

Medical Records 3/07 thru 12/07

Pump Refill 1/07 thru 6/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This man sustained major injuries to the cervical and lumbar region in a work related injury. The main issues are the new intractable cervical pain and presumably cervicogenic headaches.. He had a prior fusion at 6-7 and C5-6. He has degenerative changes at C4-5 and known C2-3 mild anterior subluxation, presumably related to degenerative changes at this level. Dr. wishes to perform a C2-3 facet block to determine if this is the pain generator. If it is, he plans to proceed to a medial branch block Surgery was mentioned as a possible treatment as well.

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

First, working backwards, it is not clear if the medial branch block would be by radiofrequency or by injections. The ODG cites:

Cervicogenic headache, facet joint neurotomy

Not recommended. *Facet joint radiofrequency neurotomy is not recommended for cervicogenic headaches. A recent randomized controlled trial on patients diagnosed with this condition (based on clinical criteria), involved treatment with radiofrequency neurotomy at the C2-C6 facet joints ipsilateral to the pain. At three months the patients with neurotomy were somewhat improved, but at latter outcome measures (up to 24 months) there was no difference between patients in the sham control group from the 6th month measurement onward. (Stovner, 2004) See also [Greater occipital nerve block, diagnostic;](#) & [Greater occipital nerve block, therapeutic.](#)*

Facet joint radiofrequency neurotomy

Under study. *Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis. Studies have not demonstrated improved function. One randomized controlled trial was performed on patients with neck pain at the C3 to C7 level after a motor vehicle accident. There was a success rate of 75% with one or two treatments with a median time to return to a 50% preoperative level of pain of approximately 9 months. (Lord, 1996) A similar duration of pain relief (219 days) was found in a prospective non-randomized trial. Complete pain relief was obtained by 71% of patients (for a “clinically satisfying period”). (McDonald, 1999) A recent retrospective review was conducted on patients with diagnosed cervical facet syndrome (via controlled blocks) and found that 80% of patients had pain relief with a mean duration of 35 weeks per injection. The mean duration of relief was less at the C2-3 joint than at other levels, and was also less for patients on compensation (non-significant difference). Pain was not measured with a formal pain rating instrument. (Barnsley, 2005) (ConlinII, 2005) The procedure is not recommended to treat cervicogenic headaches (See [Facet Joint radiofrequency neurotomy, Cervicogenic Headaches...](#)*

At the same time, the ODG states:

Facet joint diagnostic blocks

Recommended prior to facet neurotomy (a procedure that is considered “under study”). *Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBB. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 27% to 63%) but*

this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself.

As such, this would imply that the ODG would justify the treatment. It further states:

Technique: The described technique of blocking the medial branch nerves in the C3-C7 region (C3-4, C4-5, C5-6, and C6-7) is to block the named medial branch nerves (two injections). Authors have described blocking C2-3 by blocking the 3rd occipital nerve. Another technique of blocking C2-3 is to block at three injection points (vertically over the joint line, immediately above the inferior articular facet at C2 and immediately below the superior articular facet at C3). (Barnsley, 1993) The volume of injectate for diagnostic medial branch blocks must be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate) as increased volume may anesthetize other potential areas of pain generation and confound the ability of the block to accurately diagnose facet pathology. (Washington, 2005) (Manchikanti, 2003) (Dreyfuss, 2003) See the [Low Back Chapter](#) for further references.

Yet, the criteria in number 10 contraindicates the role of the block if surgery is contemplated.

Criteria for the use of diagnostic blocks for facet nerve pain:

1. One set of diagnostic medial branch blocks is required with a response of $\geq 70\%$. 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
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.**

In short, the procedure is not appropriate for cervicogenic headaches, neck pain with either a future radiofrequency neurotomy or future surgical procedure. Dr. wrote (12/8/07) that if the study confirmed “this diagnosis, treatment is available in the form of medial branch neurotomy.” Therefore, the Reviewer would need to know what type of medial branch neurotomy was proposed before approval.

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)**