



**MEDICAL EVALUATORS  
OF T E X A S ASO, LLC.**

2211 West 34<sup>th</sup> St. • Houston, TX 77018  
800-845-8982 FAX: 713-583-5943

**Notice of Independent Review Decision**

**DATE OF REVIEW: DECEMBER 1, 2014**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

C1/2, C2/3 facet injection with IV Sedation.

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

This case was reviewed by a physician who holds a board certification in Physical Medicine and Rehabilitation and is currently licensed and practicing in the state of California.

**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)

**EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The patient is a male who had anterior cervical fusion followed by a posterior fusion at the C3-4 level in 2009. Reviewed MRI revealed solid osseous fusion across the disc space at C3-4, multilevel discogenic and spondylitic degenerative changes throughout the cervical spine, mild central stenosis at C2-3, and multiple levels of significant neuroforaminal encroachment. A follow-up visit dated 09/30/2014 documented the presence of status post anterior posterior fusion C3-4, followed by a work injury with persistent parasethia of the hands with increased pain in the last 2 years, moderate stenosis at C5-6 with intermittent positive Hoffmans right upper extremity, hyperreflexive lower extremity with subjective weakness, and signs of myelopathy. The patient was diagnosed with spinal stenosis of the cervical region, and osteoporosis. The treating physician ordered injection-facet joint levels; C1/2 – C2/3 with IV sedation, and injection-other levels; sub occipital with IV sedation.



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A denial for the requested service and for the appeal from GENEX dated 10/09/2014 and 10/22/2014, respectively due to lack of documented evidence to support the request per ODG guidelines.

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

The request has been submitted for C1/2 and C2/3 facet joint injections with IV sedation. The patient underwent a previous posterior fusion at C3-4 which was confirmed on last MRI. The ODG requires a failure of conservative treatments for 4-6 weeks prior to surgery which would include home exercise, PT, and NSAIDs. Additionally, the use of IV sedation may negate the effects of a block and are contraindicated unless patient has severe anxiety. No documentation was submitted regarding the failure of conservative treatments prior to this recommended intervention. As documentation for failure of conservative treatments has not been submitted and IV sedation has been requested, the request fails to meet ODG criteria. I would agree with the two previous adverse determinations and I found this case noncertified.

**ODG – Neck and Upper Back (Acute and Chronic)**

**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.

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 3<sup>rd</sup> 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 medial branch nerve innervates the facet joint, facet capsular ligaments, the interspinous and supraspinous ligaments, spinous processes and paraspinal muscles. Relief of pain could be due to blockade of nociceptive input from any combination of these. It is suggested that the volume of injectate for diagnostic medial branch blocks be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate) as increased volume may anesthetize these other potential areas of pain generation and confound the ability of the block to



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accurately diagnose facet pathology. A recent study has recommended that the volume be limited to 0.25 cc.

Epidemiology of involved levels: Using cadaver evidence facet arthrosis most commonly affects the upper cervical levels, and increased with age, and was very rare in patients less than 40 years of age. C4-5 is the most common level followed by C3-4 and C2-3. This study did not attempt to identify number of levels of involvement. (Lee, 2009) Number of levels of involvement: In a randomized controlled trial of therapeutic cervical medial branch blocks it was stated that 48% of patients had 2 joints involved and 52% had three joints involved. (Manchikanti, 2008) These levels were identified by the pain pattern, local or paramedian tenderness over the area of the facet joint, and reproduction of pain to deep pressure. (Manchikanti, 2004) Other prevalence studies from this group also indicated that the majority of patients with cervical involvement were treated at three joints. Target joints were identified as noted above. (Manchikanti, 2004). There are no studies that have actually tested levels of involvement using individual injections for diagnostic verification.

(Lord 1996) (Washington, 2005) (Manchikanti, 2003) (Dreyfuss, 2003) (Falco, 2009) (Nordin, 2009) (Cohen, 2010) See the Low Back Chapter for further references.

Complications: See Facet joint therapeutic steroid injections.

### **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  $\geq 70\%$ . 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, 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.



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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**

Recommended as outlined in specific sections: Facet joint diagnostic blocks; Facet joint radiofrequency neurotomy; & 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 diskogenic 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); & (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 is 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. (Kirpalani, 2008)

See Facet joint diagnostic blocks; Facet joint radiofrequency neurotomy; Facet joint therapeutic steroid injections.



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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
- 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**  
Neck and Upper Back (Acute & Chronic), Facet joint injections
- 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)