CASEREVIEW

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IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
C2-3 cervical facet block under fluoroscopic guidance and anesthesia
Bilateral C3-4 medial branch block under fluoroscopic guidance and anesthesia

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 10 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]:
The claimant is a XX who was injured on XXXX while XX. While XX, the XX causing XX. XX felt immediate pain in XX and noticed blood. XX was initially treated with Ibuprofen and IM injection for pain. XX reported neck pain began a XX after the injury.

On XXXX, the patient presented to XX with neck pain and tenderness. Pain was reported to radiate to the right hand with associated upper extremity paresthesias. On examination there was moderate tenderness of the cervical spine. Plan: XX was given pain medication to use PRN for severe dental pain. Recommendation to stay off work until the dental specialist visit. X-ray of the cervical spine ordered. Started on Diclofenac Sodium and Naprelan. Referred to physical therapy.

On XXXX, the patient presented to XX with continued neck pain and tenderness. XX reported being able to do activities of daily living with limitations.

On XXXX, the patient presented to XX after completing XX of physical therapy. XX noted only about a 5% improvement of XX pain with PT. XX continued to describe severe neck pain and admitted to numbness and paresthesias of the first, second, and third digits of XX left hand. XX also admitted to a decreased hand grip and at times XX will drop jars of water. XX denies right or left arm pain. It is reported that at the last visit XX was referred for cervical epidural steroid injections, however XX stated that nobody called XX to schedule. On examination XX has 4+/5 strength of left wrist extensors, wrist flexors, left bicep and left tricep. There is increased pain with neck extension. Spurling's negative bilaterally, Hoffman's sign negative bilaterally. MRI (XXXX) reported findings: Degenerative changes involving the cervical spine as described above in detail for each level. Disc osteophyte complex at C5-6 causes canal stenosis and lateral recess narrowing with the probability of nerve root

impingement not excluded. C2-3: Disc space shows disc desiccation change with no disc space narrowing. A circumferential posterior disc bulge of approximately 2 mm is present, causing indentation of the thecal sac. The AP diameter of the sac is 1cm. No lateral recess narrowing. C3-4: disc space shows desiccation change with no disc bulge or canal stenosis. The AP diameter of the sac os 1.2 cm. Impression/Plan: Patient is noted to have acute on chronic cervical pain with cervical radiculopathy associated with a C5-6 disc herniation seen on imaging. Although this is a chronic injury, XX symptoms of decreased sensation to his 1st-3rd digits of XX left hand with dropping objects and sensory loss and decreased motor function is consistent with XX complaints and imaging findings. XX was given another referral for cervical epidural steroid injection XX for pain improvement to XX but was advised that this will likely not alleviate the numbness or weakness. XX understands XX will need to try this prior to pursuing more invasive treatment options. In the interim, as XX is in a significant amount of pain which is likely muscular in original, a one-time prescription for Valium .5mg one tab 8 hours when necessary for muscle spasms was given.

On XXXX, the claimant presented to XX with complaints of neck pain. XX reported a pain rating of 7/10 and that the pain felt like constant aching pain, soreness, numbness, and tingling. Nothing helps the pain. On examination ROM was decreased and there was facet tenderness in the cervical area bilaterally at C2-3 and C3-4. Impression: sprain of ligaments of cervical spine. Plan: cervical facet block C2/3 level and C3/4 level medial branch of the dorsal ramus bilaterally. If successful, RFA with physical therapy.

On XXXX, XX performed a UR. Rationale for Denial: As outlined in ODG, cervical facet blocks are indicated for diagnostic purposes only, and there is no specific indication for treatment purposes. When considering the date of injury, the mechanism of injury, tempered by the pain drawing indicating cervical spine pain with radiation to both upper extremities this would indicate that the pathology is not within the cervical facets. Therefore, there is no specific objective clinical data presented to support this request. The request for C2-3 cervical facet block under fluoroscopic guidance and anesthesia is non-certified. The request for medial branch block is not supported. The MRI documentation demonstrated osteophyte and disc desiccation. The purpose of epidural steroid injections is to reduce inflammation and thereby reduce the symptomology. Understanding that there is a disc lesion, the presence of osteophyte formation would indicate that this intervention would not be efficacious. Therefore, this is not clinically indicated. The request for bilateral C3-4 medial branch block under fluoroscopic guidance and anesthesia is non-certified.

On XXXX, XX performed a UR. Rationale for Denial: Based upon a review of the submitted records, the prior non-certification appears to have been appropriate. The guidelines do not support a cervical facet block for patients who complain of radiating cervical pain. Although the patient stated that XX only had neck pain, the pain drawing indicated the pain was also located in the upper extremities bilaterally. Given there is insufficient scientific evidence and guideline support for this procedure for the treatment of chronic pain, the requested appeal for C2-3 cervical facet block under fluoroscopic guidance and anesthesia is non-certified.

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

The previous adverse determinations are upheld. The guidelines do not support a cervical facet block for patients who complain of radiating cervical pain. Given there is insufficient scientific evidence and guideline support for this procedure for the treatment of chronic pain, the requested appeal for C2-3 cervical facet block under fluoroscopic guidance and anesthesia, and bilateral C3-4 medial branch block under fluoroscopic guidance and anesthesia is non-certified.

PER ODG:

Facet joint diagnostic blocks	Recommended prior to facet neurotomy (a procedure that is considered “under study”). **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.

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 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 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 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.

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)**