Becket Systems
An Independent Review Organization
815-A Brazos St # 499
Austin, TX 78701
Phone: (512) 553-0360
Fax: (512) 366-9749
Email: manager@becketsystems.com

Description of the service or services in dispute:

- 64490 - Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic
- 64491 - Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic
- 01992 - Anesthesia for Other Procedures
- J2250 - Injection, midazolam hydrochloride, per 1 mg
- J3301 - Injection, triamcinolone acetonide, not otherwise specified, 10 mg/Cervical facet blocks at left C2/C3, C3/C4 levels under fluoroscopy with anesthesia between XXXX and XXXX

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified Anesthesiology

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)

Patient Clinical History (Summary)
XXXX was diagnosed with a sprain of ligaments of the cervical spine.

XXXX was a XXXX who sustained a work-related injury on XXXX to XXXX right hand, wrist, ankle, foot and right lower leg when XXXX was XXXX.

Per a visit note dated XXXX by XXXX, XXXX presented for low back pain and neck pain. The pain was rated as 7-9/10. XXXX was able to stand for more than 30 minutes, sit for more than 30 minutes and walk for more than 30 minutes. Pain level at the worst was 7-9/10 and at best was 4-6/10. There was a constant aching pain, which was relieved after taking the medications. On XXXX, the examination of the neck showed a decreased range of motion with flexion, extension and bilateral rotation.

An MRI of the cervical spine dated XXXX, documented moderately limited examination due to motion artifact, 2-mm disc protrusions were seen at C5-C7 and there was suspected 2-mm disc protrusion at C4-C5. At C5-C6, there was moderate right foraminal narrowing was noted.

The treatment to date included medications and physical therapy, which did not provide significant relief.

Per a utilization review decision letter dated XXXX, the requested service of cervical facet block at the left C2-C3 and C3-C4 levels under fluoroscopy with anesthesia between XXXX and XXXX was denied. The primary reason for determination was the requested service was non-certified. Additionally, the examination did not sufficiently evaluate for any radicular and/or neurologic findings in the cervical area to rule out a neurological etiology of pain symptoms.

Per a utilization review decision letter dated on XXXX, the requested service was denied. The reason for the determination was the requested service of cervical facet blocks was not medically necessary as there were limited objective findings that would validate facet joint pain and guidelines did not support the use of facet block for radiating pain.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

This patient presented with a clinical picture that suggested facet mediated pain. In a review dated XXXX, the reviewer stated that "the examination did not sufficiently evaluate for any radicular and/or neurologic findings in the cervical area to rule out a neurological etiology of pain symptoms." However, the provider recorded an examination that included neurologic findings. In a review dated XXXX, a reviewer stated that "there were limited objective findings that would validate facet joint pain." However, the provider documented the classic signs of facet mediated pain, i.e. rotational and/or axial vertebral pain in XXXX examination. So, I approve of the requested facet medial branch block, with mild sedation and steroid, because the provider adequately documented adequately the patient's clinical presentation.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation
- ☐ Policies and Guidelines European Guidelines for Management of Chronic Low Back Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines

Neck and Upper Back (Acute and Chronic) (updated 10/12/17)
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)

- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)