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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Cervical facet block, medical branch of the dorsal ramus C2/C3, C3/C4 level bilaterally.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified PM&R
Board Certified Pain Medicine
Board Certified Addiction Medicine

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X 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 patient is a XXXX whose date of injury is XXXX. The mechanism of injury is not described. MRI of the cervical spine dated XXXX reveals there is ACDF from C2 to C6 with a metallic anterior fusion. The patient is status post cervical fusions at C3-4 and C5-6 level. The patient underwent re-exploration of cervical wound, removal of anterior cervical plate, C5 to C6 anterior cervical discectomy and partial colpectomy at C5 and C6, C5 to C6 PEEK interbody spacer placement, C5 to C6 anterior cervical plate fixation on XXXX. Office visit note dated XXXX indicates that XXXX left C6 radiculopathy spontaneously resolved. However, it returned with neck and right lateral upper extremity pain with right middle finger pain. Office visit note dated XXXX indicates that the patient has undergone 5 spine surgeries, and the last 2 were posterior fusions. Office visit note dated XXXX indicates that XXXX continues to have pain going down both arms and limited range of motion due to pain. Medication is listed as XX. On physical examination there is tenderness along the cervical spine and there is tenderness over the trapezius muscle groups bilaterally. There is no sensory loss. Assessment notes cervical neuropathy and cervicalgia. Office visit note dated XXXX indicates that the patient complains of neck pain and headaches. Pain level is 7-9/10. On physical examination there is decreased flexion, extension of the cervical spine. There is facet tenderness in the cervical area bilaterally at C2-3 and C3-4. There is facet pain on spine rotation/extension/flexion and palpation and axial loading of the cervical spine. Initial request for Cervical facet block, medical branch of the dorsal ramus C2/C3, C3/C4 level bilaterally was non-certified on XXXX noting that ODG notes that therapeutic intraarticular and therapeutic medial branch blocks are not recommended. However, if the provider agrees to perform anyway, there should be no evidence of radicular pain, spinal stenosis or previous fusion. In this case, the claimant presents with ongoing axial neck pain following injury in XXXX. Examination reveals positive facet findings; however, imaging reveals that the patient is fused at the requested levels. The requested procedure is not supported at fused levels. The denial was upheld on appeal dated XXXX

noting that per ODG, facet interventions are not recommended at levels of prior fusion. Also, a plan to perform the procedure under monitored anesthesia care is noted despite ODG guidelines which state that sedation is not recommended for diagnostic facet blocks. There are no extenuating circumstances to support an exception to the guidelines.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the clinical information provided, the request for Cervical facet block, medical branch of the dorsal ramus C2/C3, C3/C4 level bilaterally is not recommended as medically necessary, and the two previous denials are upheld. The Official Disability Guidelines note that the requested blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. The submitted clinical records indicate that the patient has undergone prior fusion procedure at the planned injection levels. Additionally, there is no documentation of any recent active treatment. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Board Certified Addiction Medicine
NY 240813-1, NYWC 240813-6B, TX P6849
Official Disability Guidelines Treatment Index, 23nd edition online, 2018-Neck and Upper Back
Chapter updated 05/04/18
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.
Complications: See Facet joint therapeutic steroid injections.