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Description of the service or services in dispute:

Bilateral cervical facet blocks at the C2-C3 and C3-C4 levels, medial branch of dorsal ramus. AND/OR
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
77003 – Fluoroscopic Guidance
J2250 – Injection, XX, per 1 mg
J3301 – Injection, XX, not otherwise specified, 10 mg

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

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Overturned (Disagree)
- ☐ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XXXX is a XXXX year-old XXXX with a diagnosis of sprain of ligaments of cervical spine, initial encounter (S13.4XXA). The date of injury was XXXX. XXXX used to work for 65 hours per week. The main characteristics included sit down, bending, lifting or pulling up to 70 pounds. XXXX reported a loss of work due to the injury.

On XXXX, XXXX was seen by XXXX for neck pain. The pain radiated into the left upper extremity. The pain was described as constant, burning and throbbing, and was rated as 7-9/10. XXXX denied any relieving factors. The associated complaints included headaches. XXXX was able to stand, sit and walk for less than 30 minutes. On examination, facet tenderness was noted bilaterally in the cervical area. There was spasm at the C2-C3 and C3-C4 levels.

The treatment to date included medications and physical therapy with minimum or no help.

An MRI of the cervical spine dated XXXX showed a broad-based right paracentral disc herniation at C2-C3 measuring 1 mm anterior-posterior, which flattened the anterior aspect of the thecal sac. At C3-C4, there was a broad-based posterior central disc herniation measuring 2.5 mm anterior-posterior, which flattened the anterior aspect of the spinal cord and resulted in mild central canal stenosis. There

was also mild-to-moderate left neural foraminal stenosis. At C4-C5, there was a broad-based right to left paracentral disc herniation measuring up to 3.5 mm anterior-posterior, which flattened the anterior aspect of the spinal cord and resulted in mild-to-moderate central canal stenosis. There was also severe right and moderate left neural foraminal stenosis. At C5-C6, there was a broad-based right to left paracentral disc herniation measuring up to 3 mm anterior-posterior, which flattened the anterior aspect of the spinal cord and resulted in mild central canal stenosis as well as severe bilateral neural foraminal stenosis. There was a broad-based posterior central disc herniation measuring 3 mm anterior-posterior, which flattened the anterior aspect of the spinal cord at the level of C6-C7. At T2-T3, T3-T4 and T5-T6, there was posterior central disc herniation measuring 1.5 mm anterior-posterior, which flattened the anterior aspect of the thecal sac.

Per a utilization review decision letter dated XXXX, the requested service was denied by XXXX.

Per a utilization review decision letter dated XXXX, the requested service was denied by XXXX.

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

In XXXX, the patient suffered an injury to the neck, where after extensive PT and medication management was used, but was unsuccessful. Subsequently, the patient was referred to XXXX who evaluated the patient. Although the MRI showed multilevel disc disease, the provider diagnosed facet mediated pain and requested a bilateral two level medial branch under mild sedation in two separate sessions Documentation states that the patient has anxiety and needs sedation – XX was to be used, no XX. If successful, a XX was planned. Two prior utilization reviews were performed denied the requested treatment.

I cannot find fault with the provider's documentation nor line of reasoning. The pain appears to be facet-medated. Conservative treatment has failed. The patient does not have a clear cut picture of cervical radiculopathy. Surgery has not been performed nor is planned. Given the documentation available, the requested service(s) is considered medically necessary.

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 um knowledgebase
- ☐ 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 Chapter (Acute and Chronic) (updated 05/04/18)

  <u>Facet joint pain, signs & symptoms</u>

Recommended as outlined in specific sections: Facet joint diagnostic blocks; Facet joint radiofrequency neurotomy; and 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 discogenic 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); and (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)

<u>Facet joint diagnostic blocks</u>

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.

- ☐ 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)