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:

Cervical Facet Block

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:

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

Patient Clinical History (Summary)

XXXX is a XXXX who was diagnosed with cervicalgia and carpal tunnel syndrome of the unspecified upper limb.

XXXX was evaluated by XXXX, on XXXX for the neck pain and headaches. The pain radiated into the left upper extremity. On examination, neck range of motion was decreased. Flexion and extension, looking to left and right, were decreased. Facet tenderness in the cervical area was noted on the left. The assessment was a sprain of ligaments of the cervical spine. C2-C3 and C3-C4 facet pain was noted on spine rotation/extension/flexion and palpation and axial loading of the cervical spine. The plan was administration of a cervical facet block medial branch dorsal ramus at the C2-C3 level, on the left.

The prior treatments included medications, surgeries and physical therapy.

An MRI of the cervical spine dated XXXX showed broad-based posterior disc protrusion at C3-C4, mild bilateral neural foraminal narrowing, broad-based posterior disc protrusion at C4-C5, mild right neural foraminal narrowing, broad-based posterior disc protrusion at C5-C6, broad-based posterior disc protrusion at C6-C7, moderate-to-severe bilateral neural foraminal narrowing and borderline mild central canal stenosis, broad-based posterior disc protrusion at C7-T1 and multilevel cervical facet arthrosis.

Per a utilization review letter dated XXXX by XXXX, based on the clinical information submitted for the review and using the evidence-based peer-reviewed guidelines, the request for cervical facet block medial branch of the dorsal ramus C2/C3 level on the left, was non-certified. The patient was recently

diagnosed with cervical radiculopathy, particularly at the left C6 level. An EMG/NCV had been ordered for XXXX upper extremities; however, the report was not submitted with the request. Clarification was needed regarding the patient's pain generators and why facet medial branch blocks were being chosen over treatment for XXXX cervical radiculopathy.

Per a utilization review letter dated XXXX by XXXX, based on the clinical information submitted for the review and using the evidence-based peer-reviewed guidelines, the request for cervical facet block medial branch of the dorsal ramus C2/C3 level on the left, was not certified. There were radicular symptoms to the upper extremity. There was no facet-mediated pain. There was no exhaustion of lower levels of care.

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

In XXXX review dated XXXX; the review noted that the patient has a cervical radiculopathy with evidence of disc herniation at levels C3-T1, but only mild facet degeneration at these levels.
The review asked for clarification this patient's primary pain generator and why facet joint injections are being requested over an ESI. Furthermore, it was not clearly established if the patient had active rehabilitative efforts such as physical therapy prior to the consideration of this request. Both of these conclusions are accurate.

In XXXX review dated XXXX; the review noted that there were subjective complaints of radicular symptoms in the upper extremity, without true objective documentation of facet-mediated pain. The patient was to undergo electrodiagnostic testing, but this was not provided for review.

The key issue in these reviews is that the patient has radicular pain that appears to be the predominant symptom. The guidelines clearly state that diagnostic facet injections are "Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally."

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

ODG Treatment Integrated Treatment/Disability Duration Guidelines
Neck and Upper Back (Acute and Chronic) (updated 10/12/17)
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)

☐ 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)