



## Complete Summary

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### GUIDELINE TITLE

Guideline on diagnostic facet medial nerve branch blocks and facet neurotomy.

### BIBLIOGRAPHIC SOURCE(S)

Washington State Department of Labor and Industries. Guideline on diagnostic facet medial nerve branch blocks and facet neurotomy. Provider Bull 2005 Aug;(PB 05-11):1-6. [7 references]

### GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Washington State Department of Labor and Industries. Guideline on facet neurotomy. Provider Bull 2003 Sep;(PB 03-11):1-6.

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## SCOPE

### DISEASE/CONDITION(S)

Cervical or lumbar facet (zygapophyseal) joint pain

### GUIDELINE CATEGORY

Diagnosis  
Evaluation  
Management  
Treatment

## **CLINICAL SPECIALTY**

Anesthesiology  
Family Practice  
Internal Medicine  
Neurology  
Orthopedic Surgery

## **INTENDED USERS**

Advanced Practice Nurses  
Hospitals  
Physician Assistants  
Physicians  
Utilization Management

## **GUIDELINE OBJECTIVE(S)**

- To replace a previous Provider Bulletin and to clarify the department's payment policy on the number of joint levels for diagnostic medial nerve branch blocks and facet neurotomies that may be performed on the same day
- To provide information on the diagnosis and treatment criteria for cervical or lumbar facet joint pain and the reactivation protocol following a facet neurotomy

## **TARGET POPULATION**

The injured worker with cervical or lumbar facet joint pain that requires facet neurotomy

## **INTERVENTIONS AND PRACTICES CONSIDERED**

### **Diagnosis**

1. Diagnostic medial nerve block or facet joint block
2. Documentation of pain relief using standardized form

### **Treatment/Management**

1. Facet neurotomy
2. Formal plan for reactivation, including outpatient physical therapy or occupational therapy, or work hardening

## **MAJOR OUTCOMES CONSIDERED**

Not stated

## **METHODOLOGY**

## **METHODS USED TO COLLECT/SELECT EVIDENCE**

Searches of Electronic Databases

**DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

The guideline developer performed literature searches of the U.S. National Library of Medicine's Medline database to identify data related to the injured worker population.

The current medical literature was reviewed for randomized, double blind control trials on facet neurotomy in the treatment of cervical or lumbar facet (zygapophyseal) pain.

**NUMBER OF SOURCE DOCUMENTS**

Not stated

**METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Not stated

**RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

Not applicable

**METHODS USED TO ANALYZE THE EVIDENCE**

Review

**DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Not stated

**METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

**DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

The guideline is based on a literature review of the current scientific information regarding facet neurotomy in the treatment of facet joint pain and on expert opinion from actively practicing physicians who regularly treat facet joint pain.

**RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

**COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

**METHOD OF GUIDELINE VALIDATION**

External Peer Review  
Internal Peer Review

**DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

The guideline is further refined after input from other community-based practicing physicians.

**RECOMMENDATIONS**

**MAJOR RECOMMENDATIONS**

**Criteria for Cervical or Lumbar Facet Neurotomy**

**Inclusion Criteria**

<b>CONSERVATIVE CARE</b>	<b>CLINICAL FINDINGS</b>		
		<b>SUBJECTIVE/OBJECTIVE</b>	<b>DIAGNOSTIC TESTS</b>
Failure of 6 months of noninvasive therapy such as physical therapy, medications, or manual therapy (mobilization/manipulation)	<b>AND</b>	Non-radicular neck or back pain  <b>AND</b> Segmental pain or tenderness at the level of the potentially involved facet and not more than 2 joint levels bilaterally or 3 joint levels unilaterally  <b>AND</b> Neurologically intact for the region involved  <b>OR</b> If neurologic deficit is present, it should be addressed in the treatment plan.	<b>AND</b> Diagnostic testing as required to rule out any correctable structural lesion to include CT or MRI. Diagnostic blocks should not involve more than 2 joint levels bilaterally or 3 joint levels unilaterally.  <b>AND</b> Minimum of at least 2 differential local anesthetic blocks. One block must be of the medial branch of the

		CLINICAL FINDINGS	
CONSERVATIVE CARE		SUBJECTIVE/OBJECTIVE	DIAGNOSTIC TESTS
			<p>dorsal ramus innervating the targeted facet joints; the other block may be an intra-articular facet joint block.</p> <p><b>AND</b></p> <p>Differential blocks may be either 0.5 mL total volume of a short acting local anesthetic (2% to 4% lidocaine); or 0.5 mL total volume of a long acting local anesthetic (0.5% to 0.75% bupivacaine).</p> <p><b>AND</b></p> <p>Steroid may be used with a local anesthetic for the intra-articular block but <b>total volume of both</b> local and steroid should not exceed 0.5 mL for cervical injection and 0.75 mL for lumbar injection.</p> <p><b>AND</b></p> <p>Minimum of 80% pain relief following each block while performing</p>

		<b>CLINICAL FINDINGS</b>	
<b>CONSERVATIVE CARE</b>		<b>SUBJECTIVE/OBJECTIVE</b>	<b>DIAGNOSTIC TESTS</b>
			<p>activities that previously provoked pain. Documentation of pain relief should be a patient-generated report in real-time, every 15 minutes for the first six hours following the block.</p> <p><b>AND</b></p> <p>Duration of pain relief should be consistent with the expected duration of the local anesthetic injected (at least 1 hour for short acting and at least 2 hours for long acting local anesthetic).</p> <p><b>AND/OR</b></p> <p>Placebo controlled blocks may be used to resolve any ambiguity of results of local anesthetic blocks.</p>

Abbreviations: CT, computed tomography; MRI, magnetic resonance imaging

**Exclusion Criteria That Would Require Utilization Review (UR) Physician Review**

- Radiculopathy
- Anticipated cervical, thoracic, or lumbar surgery, or surgery for any other condition

- Previous fusion at the targeted level
- Diagnosed with a psychiatric condition likely to interfere with diagnostic accuracy of the workup protocol or with recovery following the anticipated procedure
- Multiple, focal, chronic pain syndromes (i.e., complex regional pain syndrome [CRPS], fibromyalgia, chronic fatigue syndrome)
- Intravenous (IV) sedation during a diagnostic block

### **Documentation of Pain Relief Following Diagnostic Medial Nerve Branch Block or Facet Joint Block**

No pain medication should be taken for four hours prior to each diagnostic medial nerve branch block or facet joint block. No IV sedation should be administered before or during a diagnostic block except in an extreme case of anxiety. Prior to the block, pain should be reproducible with positioning of the patient, to at least a "4" on a 0-10 pain scale.

After each diagnostic block the injured worker must document the level of pain relief obtained using the *Neurotomy Workup Pain Relief Report Form* found in the original guideline document. The form may be copied as needed. The injured worker is to engage in the activities that previously produced pain and document the level of pain relief obtained every 15 minutes for a minimum of six hours following each block, or until their usual level of pain returns, whichever occurs first. The worker is to return the completed form to the physician at the next scheduled office visit. Place a copy of the *Pain Relief Report Form* in the medical record, send a copy to the department, and another copy to the department's utilization review vendor if a facet neurotomy is requested.

### **Reactivation and Maximum Medical Improvement following a Facet Neurotomy**

Prior to a facet neurotomy, a formal plan for reactivation must be developed, and agreed upon by the injured worker. If indicated, vocational assessment and/or plan development should be considered prior to the procedure. Progressive reactivation, as appropriate based on the injured worker's condition, may include up to four weeks of outpatient physical therapy or occupational therapy, or work hardening.

A facet neurotomy should be the final procedure performed before an injured worker is expected to be at maximum medical improvement. Payment for repeat facet neurotomy at the same level and the same side will not be authorized. It is important that the injured worker receive a facet neurotomy when it will provide the maximum functional benefit. In almost all cases, that will be when the injured worker is about to return to work or enter vocational rehabilitation. For these reasons, at the conclusion of the post procedure reactivation period, the injured worker should be at maximum medical improvement.

### **CLINICAL ALGORITHM(S)**

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

The guideline is based on a literature review of the current scientific information regarding facet neurotomy in the treatment of facet joint pain, and on expert opinion from actively practicing physicians who regularly treat facet joint pain.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

Patients with a clear diagnosis of medial branch nerve pain may benefit from a facet neurotomy. At the conclusion of the post-procedure reactivation, the injured worker should be at maximum medical improvement.

### POTENTIAL HARMS

Not stated

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

- The Office of the Medical Director works closely with the provider community to develop medical treatment guidelines on a wide range of topics relevant to injured workers. Guidelines cover areas such as lumbar fusion, indications for lumbar magnetic resonance imaging (MRI), and the prescribing of controlled substances. Although doctors are expected to be familiar with the guidelines and follow the recommendations, the department also understands that guidelines are not hard-and-fast rules. Good medical judgment is important in deciding how to use and interpret this information.
- The guideline is meant to be a gold standard for the majority of requests, but for the minority of workers who appear to fall outside of the guideline and whose complexity of clinical findings exceeds the specificity of the guideline, a further review by a specialty-matched physician is conducted.
- The guideline-setting process will be iterative, that is, although initial guidelines may be quite liberally constructed, subsequent tightening of the guideline would occur as other national guidelines are set, or other scientific evidence (e.g., from outcomes research) becomes available. This iterative process stands in contrast to the method in some states of placing guidelines in regulation. Although such regulation could aid in the dissemination and quality oversight of guidelines, flexibility in creating updated guidelines might be limited.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

This guideline is published in a provider bulletin which is mailed to all health care providers (e.g., physicians, osteopaths, physician assistants, nurse practitioners, pain clinics, and pharmacists) that have a provider number with the Washington State Department of Labor and Industries. Specialized training on the guideline is also given to all department claim managers.

In addition, surgical guidelines established by the Department of Labor and Industries in collaboration with expert medical specialists have been implemented in the context of the Utilization Review (UR) program (complete details regarding the Utilization Review program can be found on the [Washington State Department of Labor and Industries Web site](#)). It has been critical in contract negotiations with UR vendors to specify that the vendor is willing to substitute Labor and Industries-generated guidelines for less specific standards already in use by the company. The Department of Labor and Industries initiated an outpatient UR program, and this has allowed full implementation of guidelines related to outpatient procedures (e.g., carpal tunnel surgery, magnetic resonance imagings [MRIs]). The scheduled drug use guideline has been widely disseminated and used internally, but has not been formally implemented in a UR program.

The intention of the joint Department of Labor and Industries and expert medical specialist panels was to develop treatment guidelines that would be implemented in a nonadversarial way. The joint panel tried to distinguish between clear-cut indications for procedures and indications that were questionable. The expectation was that when surgery was requested for a patient with clear-cut indications, the request would be approved by nurse reviewers. However, if such clear-cut indications were not present, the request would not be automatically denied. Instead, it would be referred to a physician consultant who would review the patient's file, discuss the case with the requesting surgeon, and make recommendations to the claims manager.

### IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better

### IOM DOMAIN

Effectiveness  
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### **BIBLIOGRAPHIC SOURCE(S)**

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### **ADAPTATION**

Not applicable: The guideline was not adapted from another source.

### **DATE RELEASED**

2003 Sep 15 (revised 2005 Aug)

### **GUIDELINE DEVELOPER(S)**

Washington State Department of Labor and Industries - State/Local Government Agency [U.S.]

### **SOURCE(S) OF FUNDING**

Washington State Department of Labor and Industries

### **GUIDELINE COMMITTEE**

Washington State Department of Labor and Industries (L&I)

### **COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

*Medical Director, Washington State Department of Labor and Industries (L&I):*  
Gary Franklin, MD

### **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

Not stated

### **GUIDELINE STATUS**

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## **GUIDELINE AVAILABILITY**

Electronic copies: Available in Portable Document Format (PDF) from the [Washington State Department of Labor and Industries Web site](#).

Print copies: L&I Warehouse, Department of Labor and Industries, P.O. Box 44843, Olympia, Washington 98504-4843.

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following is available:

- Facet neurotomy workup pain relief report form.

Electronic copies: Available in the original guideline document from the [Washington State Department of Labor and Industries Web site](#).

## **PATIENT RESOURCES**

None available

## **NGC STATUS**

This summary was updated by ECRI on May 26, 2004. The information was verified by the guideline developer on June 14, 2004. This summary was updated by ECRI on January 16, 2006. The updated information was verified by the guideline developer on February 2, 2006.

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