AccuReview

An Independent Review Organization
569 TM West Parkway
West, TX 76691
Phone (254) 640-1738
Fax (888) 492-8305

February 27, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Epidural Steroid Injection for the Cervical/Thoracic Spine (C7-T1)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board certified in Anesthesiology with over 15 years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ 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]:
XXXX: Office Visit dictated by XXXX. CC: low back pain and neck pain. HPI: XXXX who was injured on the job in XXXX when XXXX. XXXX was diagnosed with a herniated disk and underwent three-level anterior cervical discectomy and fusion in XXXX that helped some, but not enough and XXXX still has significant residual neck pain radiating toward XXXX upper extremities. XXXX has a chronic LBP. XXXX neck pain radiates to both XXXX upper extremity, aching, throbbing and stabbing in character and feels tingling and numb. Pain 7/10 and sleep is disturbed by pain. Current Medications: Tramadol HCL, Lyrica, Aleve and ibuprofen. Past Medical: DM type 2 and HTN. Prolonged standing and sitting, lifting any heavy objects and flexing and extending back and neck increase the pain. PE: musculoskeletal: well-healed midline scar at L4-S1 with mild-to-moderate tenderness in the midline and bilateral paravertebrally at L3-S1. Assessment: 1. Chronic neck pain and bilateral upper extremity radiculopathy, 2. S/P anterior cervical disckectomy and fusion and possible cervical degenerative disk disease and facet arthropathy, 3. Chronic low back pain, 4. Failed back surgery syndrome of the lumbar spine with possible lumbar degenerative disk disease and facet arthropathy. Plan: 1. UDS, 2. Wean down and off pain medications if pain improves, 3. Restart cervical and lumbar spine PT, 4. Tramadol, 5. Lyrica, 6. Obtain records from XXXX previous Pain Management Physician XXXX, 7. F/U in one month.

XXXX: MR Cerv Spine W/O dictated by XXXX. Impression: 1. Anterior cervical fusion from C3 through C6. Apparent solid fusion across the disc spaces at the operative levels. 2. C2-3: 3 mm cervical disc herniation contributes to narrowing the central canal to 7 mm. 3. C5-6: Operative level, Left uncovertebral joint overgrowth contributes to moderate left foraminal narrowing. 4. C6-7: 1-2 mm disc osteophyte complex, left greater than right uncovertebral joint overgrowth. 9mm central canal, moderate left and mild right foraminal narrowing. 5. C7-T1: Right posterior lateral disc herniation

contributes to moderate right foraminal narrowing.

XXXX: UR performed by XXXX. Reason for denial: ESI in the cervical spine are not routinely supported as the risk outweighs any potential benefit. Recent failure of formal physical therapy has not been documented. Also, the records have not provided substantial documentation supporting acute radiculopathy at the requested level of injection, therefore, the request would not be warranted based on the guidelines.

XXXX: Letter of Appeal dictated by XXXX. The reason for denial of the requested ESI were due to the claimant not undergoing any PT and a 1-2mm disk herniation at C6-7 without any documented radiculopathy. It is very clear that the claimant has chronic neck pain with right upper extremity radiculopathy. The pain started after an injury has chronic neck pain with right upper extremity radiculopathy. This pain started after an injury at work that is well documented in XXXX history. An MRI of cervical spine has shown a disk herniation at C7-T1 level, which is causing moderate right neural foraminal stenosis. XXXX has already undergone an anterior cervical discectomy and fusion from C3-6 in the past. The claimant has radicular pain along XXXX right upper extremity and has been through two months of regular cervical spine PT early in XXXX prior to request for this ESI. The claimant continues to have severe pain and has been on pain medications Tramadol, Lyrica and ibuprofen without relief. Requesting cervical ESI to be approved to get some relief for the claimant and so XXXX can be a productive member of the workforce and return to work.

XXXX: UR performed by XXXX. Reason for denial: The claimant completed 6 weeks of PT with no relief and has also been treated with rest, ice, heat, and medications. XXXX reported radiculopathy is most likely coming from the disc bulge and requests an epidural steroid injection. The ODG states that ESI are not recommended. The location of the pain is between the neck and shoulders on both sides. The claimant reported clicking of the neck and pain was rated 8/10 at its worst and 4/10 at its best. Pain was described as burning. However, the risk of the procedure outweighs the benefits and guidelines do not support the requested procedure.

XXXX: Request for IRO Review dictated by XXXX. The claimant continues to have chronic neck pain with right upper extremity radiculopathy. XXXX is quite distressed and frustrated because of the delay in services for XXXX. XXXX continues to be off work and that is extremely for XXXX and we are requesting cervical ESI to be approved to get some relief for the claimant to be a productive member of the workforce and return to work.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the records submitted and peer-reviewed guidelines, this request is non-certified. The claimant completed 6 weeks of PT with no relief and has also been treated with rest, ice, heat, and medications. Per ODG, ESI are not recommended. The location of the pain is between the neck and shoulders on both sides. The claimant reported clicking of the neck and pain was rated 8/10 at its worst and 4/10 at its best. Pain was described as burning. However, the risk of the procedure outweighs the benefits and guidelines do not support the requested procedure. Therefore, this request for Epidural Steroid Injection for the Cervical/Thoracic Spine (C7-T1) is non-certified.

Per ODG:

Epidural steroid injection (ESI)	**While not recommended, cervical ESIs may be supported using Appendix D, Documenting Exceptions to the Guidelines, in which case:** **Criteria for the use of Epidural steroid injections, therapeutic:** *Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating*

	progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. (1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). (3) Injections should be performed using fluoroscopy (live X-ray) for guidance (4) No more than two nerve root levels should be injected using transforaminal blocks. (5) No more than one interlaminar level should be injected at one session. (6) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (7) Repeat injections should be based on continued objective documented pain and function response. (8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. (9) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. (10) Cervical and lumbar epidural steroid injection should not be performed on the same day; (11) Additional criteria based on evidence of risk: (i) ESIs are not recommended higher than the C6-7 level; (ii) Cervical transforaminal ESI is not recommended; (iii) Particulate steroids should not be used. (Benzon, 2015) (12) Excessive sedation should be avoided. **Criteria for the use of Epidural steroid injections, diagnostic:** If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below: (1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies; (2) To help to determine pain generators when there is evidence of multi-level nerve root compression; (3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g., dermatomal distribution), and imaging studies have suggestive cause for symptoms but are inconclusive; (4) To help to identify the origin of pain in patients who have had previous spinal surgery.

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

☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

☐ **INTERQUAL CRITERIA**

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

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**