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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Cervical ESI

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician has 21 years of experience in Physical Medicine and Rehabilitation.

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]:
The claimant is a XXXX status post injury on XXXX. XXXX is requesting Cervical ESI.

XXXX: **XXXX** Assessment: Regressing. Pt. present with allodynia and secondary hyperalgesia grossly around area of complaint.

XXXX: MRI Cervical Spine W/O contrast interpreted by **XXXX**. Moderate left neural foraminal narrowing at the C3-C4 level, moderate bilateral neural foraminal narrowing at the C4-C5 level, mild to moderate bilateral neural foraminal narrowing at the C5-C6 level, the moderate bilateral neural foraminal narrowing at the C6-C7 and C7-T1 levels.

XXXX: OVN by **XXXX**. The claimant was present for evaluation of neck pain, right arm pain. The neck pain is localized to the right lateral cervical region and has been present for 6 months. It's a 10/10 severity.

XXXX: OVN by **XXXX**. Claimant was seen for pain in XXXX lower neck on the right. There is numbness and tingling present in the right upper extremity. This began on **XXXX**. This started after a **XXXX**. XXXX stated that XXXX was a **XXXX**. There was no loss of consciousness and EMS was called to the scene. XXXX stated the pain has gotten worse since XXXX injury. Pain level 9/10. XXXX has tried OTC medications, rest, activity home exercise, and stretching. Medications: XX 10mg, XX 4mg, XX 15mg, XX, XX, XX XX.

XXXX: ESI by **XXXX**: Cervical ESI, IL C7-T1

XXXX: UR performed by **XXXX**. Rationale for denial: There is no documentation of specific rationale to support the use of the treatment outside of the guidelines. There is no clear documentation of objective radicular findings in the requested nerve root distributions. Therefore, certification of the requested Cervical Epidural Steroid Injection is not recommended.

XXXX: Progress notes by **XXXX**. Claimant reported pain 8/10 at its worst and 5/10 at its best. Subjective findings of neck pain and pain in the C5 to C8 distributions; objective findings include positive Spruling's on the right and limited strength; diagnoses include cervical radiculopathy. XXXX stated increase pain of the cervical spine and bilateral shoulder since XXXX last office visit. XXXX describes pain as aching, dull sharp, stabbing. XXXX states XXXX is having weakness in the arm. XXXX stated XXXX has intermittent tingling in the arm. The claimant has failed therapy within the past 6 months PT and home therapy.

XXXX: UR performed by XXXX. Rationale for denial: There remains no documentation of a specific rationale to support the use of the treatment outside of the guidelines. Despite documentation of conservative treatment and given the XXXX plan for initiation of PT, there is no documentation that the claimant has failed additional conservative care. (PT). Therefore, certification is still not recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous determination has been upheld. Denial of cervical Epidural Steroid injection interlaminar at C7-T1 is OVERTURNED/DISAGREED WITH since despite no objective sensory, motor or reflex deficits following a nerve root distribution, there is objective finding of neural tension sign on exam in positive Spurling's maneuver reproducing symptoms of pain and tingling in the right upper extremity corroborated by Electromyographic testing of acute and chronic radiculopathy Right C 5, 6, 7, 8.

Also with multilevel neuroforaminal narrowing on the Cervical MRI, this Cervical ESI represents diagnostic phase testing so as to guide an effective future treatment plan in this chronic case now nearly one year since injury.
There is documentation of an adequate trial of conservative care including activity modification, formal physical therapy, home exercises, and medication over this long period of time.

The request for Cervical Epidural Steroid injection is found to be not medically necessary.

ODG Guidelines:

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, the reduction of medication use and the avoidance of surgery, but this treatment alone offers no significant long-term functional benefit.

(1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, muscle relaxants, and neuropathic drugs).
(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
(4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is

inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases, a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.
(5) No more than two nerve root levels should be injected using transforaminal blocks.
(6) No more than one interlaminar level should be injected at one session.
(7) *Therapeutic phase:* If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)
(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.
(9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.
(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)
(12) Excessive sedation should be avoided.

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)**