Parker Healthcare Management Organization, Inc.

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IRO Cert # 5301

DATE OF REVIEW: MARCH 28, 2018 AMENDED JUNE 20, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Medical Necessity of the proposed Cervical Steroid Injection C6-C7; Series of 3

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is Board Certified in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

XX	Upheld	(Agree)
☐	Overturned	(Disagree)
☐	Partially Overturned	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX who was injured on XXXX, when the neck was twisted in an XXXX. The claimant was diagnosed with neck pain and upper extremity radiculopathy. Treatment included physical therapy, use of XXXX, and chiropractic care. An MRI of the cervical spine on XXXX, documented multi-level degenerative disc changes with facet arthropathy resulting in shallow posterior disc protrusions at C4-C7. At C5-C7 there was severe left and mild right neural foraminal stenosis. Clinical correlation was recommended. The central canal was patent. An evaluation on XXXX, documented a Body Mass Index of XXXX. Medications included XXXX. There was spinal tenderness at C6-C7. Forward flexion of the cervical spine was 35 degrees and hyperextension was 75 degrees. Right lateral flexion was 50 degrees and left lateral flexion was 20 degrees. There was right lateral rotation of 80 degrees and left lateral rotation of 55 degrees. The gait and posture were normal. Strength was 4+/5 in left shoulder abduction, left biceps 4/5, and strength but otherwise measurements were 5/5. There was decreased sensation suggested in the left C6-C7 dermatome. No vibratory sensation loss was noted. An epidural steroid injection was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.
The request was previously non-certified on XXXX, due to lack of medical necessity, lack of guideline recommendation, and lack of support for a series of three epidural steroid injections. The previous non-certification is supported. Soft findings of radiculopathy were suggested. There is no evidence of electrodiagnostic testing having been performed. Repeat injections such as a series of three epidural steroid injections would not be supported without objective documentation of response to the initial injection. The guidelines do not routinely support epidural steroid injections for therapeutic treatment

due to risks. Records do not reflect a trial of muscle relaxant medication. The request for a series of three C6-C7 epidural steroid injections is not certified as it does not meet the guidelines for medical necessity.

Official Disability Guidelines Treatment Integrated Treatment/Disability Duration Guidelines Neck and Upper Back (Acute and Chronic) (updated 10/12/17) Epidural steroid injection (ESI) Not recommended based on recent evidence, given the serious risks of this procedure in the cervical region and the lack of quality evidence for sustained benefit. This treatment had been recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy), with specific criteria for use below. See Autologous blood-derived products. See also the Low Back Chapter, where ESIs are recommended as a possible option for short-term treatment of radicular pain in conjunction with active rehab efforts, but they are not recommended for spinal stenosis or for nonspecific low back pain. 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.

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

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

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

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES