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Description of the service or services in dispute:
C7-T1 interlaminar epidural steroid injection.

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-year-old XXXX who was diagnosed with bulging of the cervical intervertebral disc without myelopathy, radiculitis of the right cervical region, cervical discogenic pain syndrome and cervical myofascial pain syndrome. On XXXX, XXXX felt a pulling on the neck and shoulder when XXXX.

XXXX was evaluated on XXXX by XXXX (Physical Medicine & Rehabilitation) for a follow-up for cervical radiculopathy and shoulder pain. XXXX continued to have persistent right cervical pain with intermittent radiation down to the right shoulder region. The pain was overall improved since XXXX initial visit. The pain was described as burning, tender, shooting, sharp, electric-like, throbbing, tingling, and numbness. On examination, there was tenderness over the right cervical and right posterior shoulder region. The cervical range of motion was slightly reduced due to pain.

XXXX presented to XXXX on XXXX for a follow-up of chronic neck pain. XXXX reported no significant change in pain or function with XX, XX and home exercise program. On examination, there was tenderness over the right lower cervical region.

On XXXX, XXXX was seen by XXXX for a follow-up of XXXX complaints of neck pain. XXXX reported that the pain was getting worse. XXXX was interested in getting a second opinion. On examination, there was tenderness over the right cervical region, trapezius, levator scapulae and rhomboid muscles. Cervical range of motion was within functional limit.

The treatment to date included medications (XX, XX, XX and XX), home exercise program, physical therapy (with no benefit) and several trigger point injections (with only temporary pain relief).

An MRI of the cervical spine performed on XXXX was essentially normal for the patient of this age without significant central spinal canal stenosis or neural foraminal encroachment seen.

A utilization review determination letter dated XXXX by XXXX (Neurosurgery) indicated that the request for C7-T1 interlaminar epidural steroid injection was denied.

A reconsideration letter dated XXXX by XXXX (Anesthesiology/Pain Management) indicated that the request for C7-T1 interlaminar epidural steroid injection was non-certified. Rationale: "There was a previous adverse determination dated XXXX, whereby the request for a C7- T1 interlaminar epidural steroid injection was non-certified. The reviewer noted that the given the current clinical data, the request for C7-T1 interlaminar epidural steroid Injection was not recommended as medically necessary. A recent request for C7-T1 interlaminar epidural steroid injection was non-certified noting that the Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and / or electrodiagnostic results. The patient's physical examination noted that sensation and motor strength were Intact. There were no imaging studies and electrodiagnostic results submitted for review. There was insufficient information to support a change in determination, and the previous non-certification was upheld. The Official Disability Guidelines noted that cervical epidural steroid Injections were 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. If used, anyway, the Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by Imaging studies and or electrodiagnostic results. The submitted records failed to document a sensor or motor deficit in a dermatomal or myotomal distribution. There was no MRI or electromyography and nerve conduction velocity (EMG and NCV) provided. This reviewer could not recommend certification of the request at this time."

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

This patient presents with a clinical picture of myofascial pain syndrome and radiculitis. Although all efforts at conservative therapy have been unsuccessful, there are no clinical findings that corroborate the requisite ODG definition of radiculopathy. A cervical MRI performed in XXXX revealed an essentially normal finding with no disc disease or neuroforaminal narrowing. These two aforementioned elements are critical to the approval of a cervical ESI under the ODG. There are no exceptional factors that warrant going outside the ODG. The requested procedure is therefore not approved. I agree with the decisions of the two prior utilization reviews. Given the documentation available, the requested service(s) is considered not medically necessary.

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

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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:

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(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.

In a previous Cochrane review, there was only one study that reported improvement in pain and function at four weeks and at one year in individuals with radiating chronic neck pain. (Peloso-Cochrane, 2006) (Peloso, 2005) Other reviews have reported moderate short-term and long-term evidence of success in managing cervical radiculopathy with interlaminar ESIs. (Stav, 1993) (Castagnera, 1994) Some have also reported moderate evidence of management of cervical nerve root pain using a transforaminal approach. (Bush, 1996) (Cyteval, 2004) A previous retrospective review of interlaminar cervical ESIs found that approximately two-thirds of patients with symptomatic cervical radiculopathy from disc herniation were able to avoid surgery for up to 1 year with treatment. Success rate was improved with earlier injection (< 100 days from diagnosis). (Lin, 2006) There have been case reports of cerebellar infarct and brainstem herniation as well as spinal cord infarction after cervical transforaminal injection. (Beckman, 2006) (Ludwig, 2005) Quadriparesis with a cervical ESI at C6-7 has also been noted (Bose, 2005) and the American Society of Anesthesiologists Closed Claims Project database revealed 9 deaths or cases of brain injury after cervical ESI (1970-1999). (Fitzgibbon, 2004) These reports were in contrast to a retrospective review of 1,036 injections that showed that there were no catastrophic complications with the procedure. (Ma, 2005) The American Academy of Neurology concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) In other studies, there was evidence for short-term symptomatic improvement of radicular symptoms with epidural or selective root injections with corticosteroids, but these treatments

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did not appear to decrease the rate of open surgery. (Haldeman, 2008) (Benyamin, 2009) Some experts have said epidural steroid injections should be reserved for those who may otherwise undergo open surgery for nerve root compromise. (Bigos, 1999) There is limited evidence of the effectiveness of epidural injection of methyl prednisolone and lidocaine for chronic MND with radicular findings. (Peloso-Cochrane, 2006) The FDA has warned that injection of corticosteroids into the epidural space of the spine may result in rare but serious adverse events, including loss of vision, stroke, paralysis, and death. (FDA, 2014)

Sedation: The use of sedation during ESI remains controversial. Excessive sedation should be avoided because it prevents the patient from reporting pain and from participating in neurologic evaluation after receiving a test dose of local anesthetic. However, some experts have promoted the use of mild sedation to prevent complications due to sudden movements (Malhotra, 2009) A multidisciplinary collaboration led by the FDA recommended that sedation for ESI remain light enough to allow the patient to communicate during the procedure. (Rathmell, 2015) For a more extensive discussion, see the Pain Chapter. See also the Low Back Chapter.

Recent evidence: ESIs should not be recommended in the cervical region, the FDA's Anesthetic and Analgesic Drug Products Advisory Committee concluded. Injecting a particulate steroid in the cervical region, especially using the transforaminal approach, increases the risk for sometimes serious and irreversible neurological adverse events, including stroke, paraplegia, spinal cord infarction, and even death. The FDA has never approved an injectable corticosteroid product administered via epidural injection, so this use, although common, is considered off-label. Injections into the cervical region, as opposed to the lumbar area, are relatively risky due to the narrower epidural space, and the risk for accidental injury in the arterial system is greater in this location. (FDA, 2015) An AMA review suggested that ESIs are not recommended higher than the C6-7 level; no cervical interlaminar ESI should be undertaken at any segmental level without preprocedural review; and particulate steroids should not be used in therapeutic cervical transforaminal injections. (Benzon, 2015) According to the American Academy of Neurology (AAN), ESIs do not improve function, lessen need for surgery, or provide long-term pain relief, and the routine use of ESIs is not recommended. They further said that there is in particular a paucity of evidence for the use of ESIs to treat radicular cervical pain. (AAN, 2015) In this comparative-effectiveness study, no significant differences were found between ESI and conservative treatments. (Cohen, 2014)

- ☐ 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)

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