

# P&S Network, Inc.

P.O. Box 48425, Los Angeles, CA 90048

Ph: (310)423-9988 Fx: (310)423-9980

## Notice of Independent Review Decision

**DATE OF REVIEW:** November 16, 2007

**IRO CASE #:**

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

This case was reviewed by a Neuro Surgeon, Licensed in Texas. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Cervical epidural steroid injection

### **REVIEW OUTCOME**

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

Upheld (Agree)

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were not provided to the IRO.
- o October 9, 2007 utilization review report
- o October 30, 2007 utilization review report
- o employer's first report of injury
- o January 10, 2007 noticed and disputed issue letter from                      June 27, 2006
- o chart notes from
- o June 30, 2006 through October 18, 2006 reports by , D.O.
- o July 12, 2006 through October 31, 2007 work status report by , D.O.
- o July 18, 2006 brain MRI report by , M.D.
- o July 30, 2006 x-ray report by , M.D.
- o August 14, 2006 cervical spine MRI by , M.D.
- o September 6, 2006 through February 9, 2007 reports by , M.D.
- o September 20, 2006 electrodiagnostic report by , M.D.
- o October 8, 2006 FCE report by
- o October 25, 2006 surveillance report by , Inc.
- o October 30, 2006 report by , M.D.
- o November 14, 2006 treatment records dictated by
- o November 21, 2006 FCE report from
- o December 1, 2006 report by , M.D.
- o December 29, 2006 electrodiagnostic consultation report by , M.D.
- o February 22, 2007 report by , M.D.
- o May 9, 2007 through October 3, 2007 from Medical Clinic
- o May 17, 2007 through June 28, 2007 reports from, M.D.
- o July 30, 2007 report by , M.D.
- o August 13, 2007 report by , M.D.

- o August 15, 2007 follow up report by , M.D.
- o October 1, 2007 report by , M.D.
- o October 19, 2007 letter from , M.D.
- o October 24, 2007 report of medical evaluation by , D.O.
- o July 25, 2006 through November 16, 2006 daily note from

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records, the patient sustained an injury on xx/xx/xx. An October 9, 2007 utilization review letter non-certified the request for a cervical epidural steroid injection. The provided rationale was that the records had no consistent clinical evidence of cervical radiculopathy. The injury was one year and three months previously. An inadequate interval history was reportedly provided. The reviewing physician noted inadequate serial exams. In addition, she stated that there was no documented imaging evidence of a neural compressive lesion. She stated that the request was not consistent with the Official Disability Guidelines.

An October 19, 2007 appeal letter was submitted by the requesting physician. This letter addresses each of the reasons for denial. Regarding the allegation that there was no consistent clinical evidence of cervical radiculopathy, the physician responded that there was evidence of right C5 radiculopathy on EMG. The physician stated that the fact that the patient had injured herself over one year and three months ago is a reason to proceed with cervical injections as the patient had failed conservative treatment for this period of time. He stated that the patient's history is well-documented in the medical records. The patient has had serial examinations that have been thorough. In addition, he stated that the patient's MRI scan clearly shows evidence of disc damage at the C3-4 and C4-5 levels as referenced in the August 2006 MRI report. The letter states that the patient meets the criteria for cervical epidural steroid injections as specified in the Official Disability Guidelines.

An October 30, 2007 utilization review report also rendered a non-certification. The reviewing doctor stated that she spoke with the requesting physician and requested additional documentation more proximate to the injury. The additional information was apparently not received.

A September 20, 2006 electrodiagnostic study demonstrated right C5 cervical radiculopathy. This study showed findings consistent with median mononeuropathy at the wrist on the right, moderate in severity. A December 29, 2006 electrodiagnostic report states that there is no conclusive EMG evidence of right or left cervical radiculopathy. It should be noted that this study demonstrated mild right and left median neuropathy at the wrist consistent with mild bilateral carpal tunnel syndrome. An MRI of the cervical spine was performed on August 11, 2006 with a conclusion of a 2 mm central posterior herniation of the nucleus pulposus at the C3-4 level with impingement on the spinal cord, 2 mm central posterior herniation of the nucleus pulposus at the C4-5 level with impingement on the spinal cord, mild narrowing of the neural foramen bilaterally at the C5-6 level, and mild narrowing of the neural foramen at the C6-7 level bilaterally.

An RME evaluation was performed on August 13, 2007. This report states that the patient reports pain in the back of the neck with radiation into the right more so than the left arm. The physician did not recommend epidural steroid injections as the patient had no objective or clinical evidence of cervical radiculopathy. He stated that the patient is not a surgical candidate at this juncture and he recommended that the patient see a designated doctor for assessment of MMI and assignment of an impairment rating.

The patient underwent a comprehensive evaluation on October 24, 2007 in the form of a designated doctor examination. The xx year old female injured her cervical spine on xx/xx/xx when she fell off a ladder at work according to this report. The report outlines previous therapy in the form of trigger point injections and extensive physical therapy with only temporary relief. The neurological examination findings included symmetric upper extremity deep tendon reflexes, normal motor strength and sensation in the lower extremities, and no loss of two-point discrimination or sensation in the right arm relative to the left. In addition, there was a significant decrease in the patient's right hand grip strength compared to the left. She is noted to be right hand dominant. The physician strongly recommended cervical epidural steroid injections and trigger point injections to the right trapezius muscle. He stated that the degree of radiculopathy described on EMG is not quite as severe as the loss of grip strength.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

The patient's electrodiagnostic studies have been inconsistent as the September 2006 report notes C5 cervical radiculopathy, while the December 2006 study stated that there is no conclusive evidence of right or left cervical radiculopathy. Both have noted the presence of carpal tunnel syndrome however. The designated doctor found a significantly decreased grip strength on the right. Deep tendon reflexes and sensation were normal in the upper extremities and no evidence of atrophy was found. It is possible that the patient's carpal tunnel syndrome can be contributing to the muscle weakness rather than compression of a cervical nerve root. In fact, no focal neurologic deficits in a dermatomal or myotomal pattern were found in the most recent examination with the exception of gross loss of right grip strength. According to the Official Disability Guidelines, criteria for cervical epidural steroid injections include that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.

This criterion has not been satisfied in this case. Therefore, my determination is to uphold the decision to non-certify a cervical epidural steroid injection.

The IRO's decision is consistent with the following guidelines:

**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

According to the Official Disability Guidelines (2007), cervical epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. In a recent Cochrane review, there was one study that reported improvement in pain and function at four weeks and also one year in individuals with chronic neck pain with radiation. (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 recent 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 recent case reports of cerebellar infarct and brainstem herniation as well as spinal cord infarction after cervical transforaminal injection. (Beckman, 2006) (Ludwig, 2005) Quadriplegia 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 recently 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) See the Low Back Chapter for more information and references.

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and 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) 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.
- 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) 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.
- 8) Repeat injections should be based on continued objective documented pain and function response.
- 9) 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.