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Notice of Independent Review Decision

DATE OF REVIEW: August 4, 2008

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 Pain Management (Board Certified), Licensed in Texas and Board Certified. 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 via catheter under fluoroscopy with x-ray

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 provided to the IRO.
- o April 15, 2008 Office Visit report from Dr.
- o April 18, 2008 MRI cervical spine from Medical Center
- o April 21, 2008 Office Visit report from Dr.
- o April 25, 2008 Operative report, CESI C6-7 through T1-2, from Dr.
- o April 25, 2008 Office Visit note from Dr.
- o May 9, 2008 Office Visit note from Dr.
- o May 16, 2008 Operative report, CESI C6-7 through T1-2 from Dr.
- o May 16, 2008 Office Visit report from Dr.
- o June 10, 2008 Office Visit report from Dr.
- o June 11, 2008 Request for a third cervical epidural steroid injection from Dr.
- o June 16, 2008 Non-certification notification of review denial for request for CESI
- o June 17, 2008 Request for appeal on denial, provider was not available for p-2-p from Dr.
- o June 20, 2008 Non-certification notification of review request for reconsideration for CESI
- o June 23, 2008 Request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records the patient is a employee who sustained an industrial injury to the cervical spine on Xx/xx/xx. He is followed with pain management with a diagnosis of post laminectomy syndrome, cervical and cervical radiculopathy. The patient's medical history includes four lumbar surgeries including a fusion at L4-5 and L5-S1, a cervical fusion at C5-7, carpal tunnel repair, arthroscopic knee surgery, high blood pressure, arthritis and depression. He is reported to smoke

one pack of cigarettes daily.

Cervical MRI of April 18, 2008 shows mild impingement at C3-4 upon the exiting nerve roots, mild impingement at C4-5 upon the exiting nerve roots, mild impingement at C5-6 on the right exiting nerve root and moderate impingement on the left exiting nerve root, at C6-7 there is moderate impingement on the right and severe impingement on the left exiting nerve root, At C7-T1 there is severe impingement on the left and mild impingement on the right exiting nerve root. There has been anterior interbody fusion at C5, C6, and C7. The patient is 6 feet in height and 260 pounds.

When reevaluated on April 15, 2008 the patient was provided trigger point injections on the left mid trapezius and levator scapulae muscles.

The patient was reevaluated on April 21, 2008. His MRI was reviewed. It shows severe nerve root impingement at C6-7, C7-T1 and moderate impingement at C5-6 and T1-2. He has constant left neck and arm pain which is burning and prevents him from sleeping. His medications include Medrol Pak, Norco, Mobic, Zanaflex, Provigil, Topamax, Paxil and Lyrica.

A cervical epidural steroid injection (CESI) was administered at the C6-7 through T1-2 spinal levels on April 25, 2008.

On May 9, 2008 the provider reported the patient was two weeks post-op from a C6-7 through T1-2 leftward biased ESI. His pain was significantly improved immediately post injection. However, that night when he went to bed he began with numbness in his lateral arm and hand. He is unable to lie on his side at night. His left arm wakes him up with severe pain if he turns on that side in bed. He has increased Lyrica which makes him drowsy.

A second CESI was administered on May 16, 2008.

Per physician notes of June 10, 2008 the patient is slightly worse since the last visit. The patient had a second ESI and did feel better immediately afterwards. He had solid relief for several weeks and then the pain began to return. He has pain in both shoulder now and his hands are shaking. He has tenderness to palpation over the left mid trapezius and levator scapular muscle and decreased sensation throughout the left upper extremity. He does not want to see a surgeon yet. He would like to continue with injections to put off surgery. His radicular symptoms are still reversible. He has had vision problems since the initial injection which could be related to the steroids. He has also had pink eye in reaction to the medication.

Request for a third CESI was not certified in review on June 16, 2008 with rationale that most guidelines currently recommend a maximum of 2 ESI and a series of three injections is no longer recommended. It was noted that ESI can offer only short term pain relief and should be used in conjunction with other rehab efforts including a home exercise program. The patient had a mixed response to the injections; the initial injection provided only a few hours of relief and the second injection provided up to two weeks of relief. Based on the mixed response, a third injection would not be indicated. Additionally, the medical records contained little information regarding improved function.

On June 17, 2008 the provider requested reconsideration as he had not been available for a peer-to-peer discussion during the initial review.

Following a peer-to-peer discussion, request for reconsideration was not certified in review on June 20, 2008 with rationale that the provider and medical records failed to document sufficient clinical evidence of ESI benefits to warrant overturning the previous adverse decision.

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

According to The Official Disability Guidelines, 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. 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).

The patient has had cervical degenerative changes and exiting nerve root compression for at least 8 years. He is overweight and has high blood pressure and continues to smoke one pack of cigarettes daily. He likely has a compromised immune and vascular system and is not likely to resolve his cervical conditions with injections. Guidelines state that ESI do not affect the need for surgery. It is noted that the patient now has vision problems since the initial injection. Injections are of short term use only and recommended early in the diagnosis (less than 100 days). ESI are considered to be administered in conjunction with an active rehabilitation program which has not been clarified. As per prior review, the response has been mixed and a third injection would not be supported by the guidelines. Therefore, my determination is to agree with the previous non-certification of the request for a third cervical epidural steroid injection via catheter under fluoroscopy with x-ray.

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
- _____ X_____ 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

The Official Disability Guidelines – Epidural Steroid Injections – Cervical – 7-7-08:

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) There is evidence for short-term symptomatic improvement of radicular symptoms with epidural or selective root injections with corticosteroids, but these treatments did not appear to decrease the rate of open surgery. (Haldeman, 2008) 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.
- (10) 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 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.