

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 3, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for cervical ESI at C5 and C6.

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

M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for cervical ESI at C5 and C6.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

DDE, Dr. , 9/14/07

Office notes, Dr. , 2/6/08, 03/26/08, 06/02/08, 07/16/08, 10/06/08

MRI cervical spine, 8/15/08

Procedure order, Dr.

Adverse Determination Letters, 10/28/08, 11/10/08

ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx when she was pulling a lever, slipped back and fell on the stairs of the bus. She was treated for pain in the left shoulder and neck. She underwent a left shoulder rotator cuff repair on 12/13/07 by Dr. . The claimant was seen for post op visits on 02/06/08 and 03/26/08. She underwent post op physical therapy for the left shoulder. On 06/02/08 the claimant was seen for follow up of her left shoulder, neck and back. The claimant had excellent range of motion of the shoulder and good strength. She continued to have complaints regarding her neck and back. On 07/16/08 the claimant complained primarily of neck and back pain. On exam she had painful and decreased cervical range of motion and tenderness of the lumbar spine and decreased range of motion. Motor strength was intact. Cervical and lumbar MRI studies were ordered.

The 08/15/08 MRI of the cervical spine showed a broad based central disc-osteophyte at C5-6 that contacted the ventral surface of the spinal cord. The AP dimension of the thecal sac measured 8 mm at C5-6. The dorsal subarachnoid space remained widely patent and there was no spinal cord edema at C5-6. There was moderate spondylosis and annular disc bulging at C6-7, but no significant canal or foraminal stenosis was seen. The left lateral recess and neural foramen at C3-4 were minimally encroached secondary to left uncovertebral osteoarthritis.

On 10/06/08 Dr. noted that the claimant's neck bothered her more than her back. She had occasional numbness in the left upper extremity. Dr. noted that the cervical MRI showed a posterior protrusion and herniation with some kyphosis at the C5-6 level. On exam there was decreased cervical range of motion and increased pain with axial compression. Spurling sign reproduced some neck and arm pain. Motor strength was intact and there were some paresthesias along the left C6 distribution. Reflexes were 2 plus. The diagnosis was protrusion C5-6 with radicular symptoms; anterior protrusion L2-3 and posterior herniation L4-5. The physician recommended an epidural steroid injection at C5-6 which was denied on peer reviews of 10/28/08 and 11/10/08.

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

Based on the records available for review, the reviewer was unable to determine if the current request is for axial neck pain or evidence of a radiculopathy. The MRI of 08/15/08 makes reference to the AP diameter of the thecal sac to be narrowed at 8 millimeters. Indications for the ESI were not outlined in the information reviewed. Motor examination showed no evidence of weakness or reflex changes. ODG guidelines were used and there is no objective evidence of radiculopathy. The reviewer finds that medical necessity does not exist for cervical ESI at C5 and C6.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Neck and Upper Back: Epidural steroid injection.

Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy).

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) 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 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.

Criteria for the use of Epidural steroid injections, diagnostic:

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) but imaging studies are inconclusive;
- (4) To help to identify the origin of pain in patients who have had previous spinal surgery.

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)