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Notice of Independent Review Decision

DATE OF REVIEW: January 2, 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 Doctor, 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

REVIEW OUTCOME

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

Overtured (Disagree)

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 January 8, 2003 physical work performance evaluation report by, L.P.T.
- o February 10, 2003 through April 23, 2003 records from, M.D.
- o May 22, 2003 reported medical evaluation by , D.C.
- o December 29, 2003 electrodiagnostic report by, M.D.
- o M.D.: December 28, 2001 report
- o M.D.: December 15, 2003 report, August 3, 2004 report
- o Chiropractic: September 24, 2002, April 26, 2002, April 11, 2002, December 3, 2001
- o MD: December 30, 2003
- o MD: September 8, 2003
- o DC: May 22, 2003 RME report, , February 21, 2003 progress report, March 17, 2003 progress report, April 21, 2003 progress report, November 13, 2000 to progress report, November 13, 2000 to chart notes, January 14, 2003 chart notes, February 12, 2003 work status report, July 21, 2003 chart notes, November 24, 2003 daily notes
- o MD: April 25, 2002 clinical note, December 20, 2001 consultation report
- o M.D.: January 28, 2003 report, December 12, 2002 report, February 4, 2003 work status report, December 12, 2002 work status report, June 14, 2005 work status report, June 14, 2005 report June 14, 2006 physical work performance evaluation report
- o Chiropractic/ D.C.: November 24, 2003 initial evaluation report, undated work status report, April 1, 2004 work status report, April 21, 2004 report, May 28, 2004 report, June 28, 2004 report, August 25, 2004 work status report
- o M.D.: June 5, 2002 electrodiagnostic report
- o October 12, 2007 peer review report, November 1, 2007 peer review report
- o Resources, Inc.: October 17, 2001 report, December 18, 2001 report, December 28, 2001 report, April 17, 2002 report, May 6, 2002 report, May 8, 2002 report, May 13, 2002 report, May 17, 2002 report, May 28, 2002 report, June 3, 2002 report, June 7, 2002 report, June 17, 2002 report,
- o March 10, 2003 report, April 15, 2003 report,

- o MD: July 19, 2003 report, October 26, 2003 report, March 17, 2004 report, March 18, 2004 report, April 28, 2004 report, September 28, 2004 report, October 20, 2004 report, November 18, 2004 report
- o Medical Center: August 6, 2001 report
- o M.D.: August 6, 2001 report, August 13, 2001 work status report, August 20, 2001 visit summary, August 20, 2001 work status report, September 5, 2001 visit summary, September 12, 2001 work status report, September 12, 2001 visit summary, September 26, 2001 work status report, September 26, 2001 visit summary
- o xx/xx/xx employer's first report of injury or illness from
- o Management Consultants: March 9, 2004 work status report, March 9, 2004 report, April 13, 2004 report
- o M.D.: March 4, 2004 x-ray report, February 11, 2004 lumbar x-ray report
- o D.C.: August 19, 2004 report, September 29, 2004 work status report, September 29, 2004 report, November 9, 2004 work status report, December 29, 2004 work status report, December 29, 2004 report, February 22, 2005 work status report, February 22, 2005 report, March 30, 2005 work status report, undated work status report, June 28, 2005 report, July 28, 2005 work status report, July 28, 2005 report, August 31, 2005 work status report, August 31, 2005 report, February 16, 2006 work status report, February 16 2006 report, March 16, 2006 work status report, March 16, 2006 report, April 13, 2006 work status report, April 16, 2006 report, May 11, 2006 work status report, May 11, 2006 report, undated work status report, June 12, 2006 report, undated work status report, January 11, 2007 work status rationale letter, March 9, 2007 work status rationale letter, undated work status report, January 5, 2005 through October 9, 2007 daily notes
- o M.D.: December 5, 2001 cervical MRI report, December 5, 2001 lumbar MRI report
- o M.D.: February 4, 2004 report
- o M.D.: June 10, 2004 work status report, June 3, 2004 report of medical evaluation, June 3, 2004 designated doctor report
- o Medical Evaluators/, D.C.: June 10, 2004 functional capacity evaluation report
- o M.D.: August 10, 2005 report, October 31, 2005 report
- o M.D.: May 23, 2006 report, June 6, 2006 report, July 18, 2006 report, August 1, 2006 report, August 29, 2006 report, September 20, 2006 sacroiliac joint injection report
- o Diagnostics: August 3, 2006 computerized muscle testing/range of motion report, August 15, 2006 computerized muscle testing/range of motion report August 29, 2006 computerized muscle testing/range of motion report September 26, 2006 computerized muscle testing/range of motion report, November 15, 2006 computerized muscle testing/range of motion report, November 27, 2006 report, December 18, 2006 report
- o M.D./, D.O.: August 9, 2006 report, September 1, 2006 letter of reconsideration, September 6, 2006 report, October 4, 2006 report, October 10, 2006 cervical discogram report, October 30, 2006 report, August 15, 2007 follow-up consultation note report
- o M.D.: November 15, 2006 work status report, November 15, 2006 orthopedic report
- o Therapy and Diagnostics: May 9, 2007 computerized muscle testing/range of motion report, May 29, 2007 computerized muscle testing/range of motion report, September 27, 2007 report
- o M.D.: May 9, 2007 orthopedic report, July 13, 2007 chart note, September 27, 2007 report
- o M.D.: September 13, 2007 designated doctor examination report
- o September 7, 2001 physical therapy notes, January 2, 2002 notes, February 11, 2002 notes, March 22, 2002 notes, April 11, 2002 notes,

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient sustained an industrial injury on xx/xx/xx involving the cervical and lumbar spine. On October 12, 2007, a request for a cervical spine epidural steroid injection at C6-7 was non-certified in utilization review. The rationale was that the patient initially reported an injury to the low back after lifting a 25 pound bag of dog food. Over one year from the date of injury in xx/xx, the patient reported neck symptoms. An RME evaluation of June 2005 demonstrated a normal cervical spine exam four years out from the injury. The report states that there is no evidence that cervical radiculopathy is due to an occupational event.

A November 1, 2007 utilization review report also rendered a non-certification for the request of an epidural steroid injection. The report states that the physical exams provided in the medical records are not consistent for unequivocal cervical radiculopathy. In addition, the peer-review physician cited the RME report from 2005 which reportedly documents no particular cervical findings. The report notes that electrodiagnostic studies are negative.

According to the independent review organization summary, the patient has undergone a total of 343 physical therapy visits, 10 work conditioning visits, 10 work hardening visits, a sacroiliac joint injection, sacroiliac arthrogram, injection discography, multiple medications, and multiple durable medical equipment prescriptions. An electrodiagnostic study was performed on June 3, 2002 on the upper extremities and was found to be normal. A December 29, 2003 electrodiagnostic examination revealed findings consistent with bilateral C6 radiculopathy, left worse than right. There was no evidence of peripheral neuropathy at that time.

A June 3, 2004 designated doctor evaluation report outlines the results of the March 4, 2004 cervical spine MRI. The MRI reportedly revealed central disc herniation at C4-5 compressing the cervical cord. Paracentral disc herniation was noted compressing the cervical cord on the left at C5-6. There was a 50% neural foraminal stenosis on the left. A central disc protrusion at C6-7 was noted impinging upon the cervical cord. A disc bulge was noted at C3-4. There was segmental bony canal stenosis and narrowing of the subarachnoid space from C3-4 through C6-7.

A designated doctor examination was performed on September 13, 2007. The patient complained of neck and back pain with bilateral numbness in the hands, but no weakness. Examination findings relevant to this request included muscle strength 5/5, neurosensory intact to two-point discrimination, no evidence of muscle wasting or atrophy, reflexes 2+ in the bilateral upper

extremities, and Waddell signs positive to axial loading and negative to trochanteric pressure. She was diagnosed with a cervical strain and lumbar strain and the physician ordered an MRI. The report states that in all medical probability, the lifting of a dog food bag did not cause the findings on the cervical MRI demonstrated. The compensable portion of this injury should be limited to an aggravation of a pre-existing condition at C5-6, but without the injury itself actually causing the physical changes found on MRI analysis according to the physician. The report states that the individual's compensability resides in an aggravation of a pre-existing condition at the cervical level of C5-6. The physician stated that as of that date's evaluation, there was no evidence of significant radiculopathy with a need for invasive treatment for the condition such as surgery.

The patient was examined on September 27, 2007 with complaints of cervical pain with radiation to the upper extremities. Relevant examination findings include positive axial compression, positive distraction, positive foraminal compression, positive Spurling, dysesthesia in the C5 and C6 dermatomes, symmetric deep tendon reflexes, adequate grip strength, positive Tinel on the left, and positive Phalen test. The physician stated that the patient has documented radiculopathy with findings on physical exam. Despite multiple therapies, the report states that the pain is persistently elevated to 8/10 or 9/10. She reports persistent throbbing pain with radiation to the bilateral upper extremities, mostly on the left side associated with tingling and numbness. She has been initially unresponsive to conservative treatment.

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

The most recent designated doctor examination produced an opinion that the patient had pre-existing findings at the C5-6 level that were aggravated by the industrial injury. She has electrodiagnostic evidence of C6 radiculopathy. The most recent examination shows dysesthesia and positive provocative orthopedic testing. Imaging findings demonstrate a 50% neural foraminal stenosis at the C5-6 level and a paracentral disc protrusion impacting the cervical cord. A central disc protrusion at C6-7 was noted impinging upon the cervical cord. She has been unresponsive to conservative treatment. Based on the Official Disability Guidelines, a cervical epidural steroid injection is indicated. Therefore, my decision is to overturn the previous determinations to non-certify the request for 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

Official Disability Guidelines (2007):

Epidural steroid injection (ESI)

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.