

## **I-Resolutions Inc.**

*An Independent Review Organization*

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### Notice of Independent Review Decision

**DATE OF REVIEW: JUNE 14, 2008**

**IRO CASE #:**

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

Cervical epidural steroid injection, C5-6

### **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 epidural steroid injection, C5-6.

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

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

Office notes, Dr. , 12/17/07, 01/14/08, 02/04/08

MRI lumbar spine, 12/21/07

MRI right shoulder, 12/21/07

Physical therapy evaluation, 1/11/08

EMG/NCS, 1/16/08

Office notes, Dr. , 4/17/08, 05/15/08, 06/12/08

Peer review, Dr. , 4/30/08  
Bone scan, 5/7/08  
Peer review, Dr. , 5/13/08  
Psych evaluation, Dr. , 5/13/08  
DDE, Dr. , 5/16/08  
Procedure report, Dr. , 6/6/08

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

The claimant fell down a stairwell on xx/xx/xx when the stairs gave way. He was hospitalized for approximately eight days and was evaluated for spinal injury. He had a history of C5-6 and C6-7 fusion in 1999. The claimant was treating for cervical, right shoulder, thoracic and low back pain. Dr. noted on 12/17/07 that a cervical MRI revealed no evidence of disc herniation. The claimant began treating with Dr. on 04/17/08. On exam the claimant had tenderness of the cervical paraspinous region, pain with range of motion and reflexes were 2 plus. Motor and sensory exams were intact. Dr noted that diagnostic studies revealed a pseudoarthrosis at C5-6 and he recommended a cervical epidural block and a psych consult due to significant depression.

The cervical MRI was done on 11/01/07 and revealed post op changes with solid interbody fusion at C5-6 and C6-7 with no mass effect on the spinal cord or nerve root sleeve. The cervical epidural steroid injection was denied on peer review. The claimant began psych treatment. A lumbar epidural steroid injection was given. Shoulder surgery was recommended at the 06/12/08 visit and Dr. again recommended a cervical epidural steroid injection.

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

Requested cervical epidural steroid injection does not appear warranted based on the information provided. Though the claimant has neck pain radiating to the right shoulder, the neurological examination is normal and the cervical MRI does not show a disc herniation or evidence of neurocompressive pathology. Rather, prior studies have indicated a concern for a pseudoarthrosis that may be contributing to the claimant's pain. There is no objective evidence of radiculopathy or neurocompressive pathology that would warrant treatment with epidural steroid injections. The reviewer finds that medical necessity does not exist for cervical epidural steroid injection, C5-6.

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:

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.

**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
- AHCP- 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)