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Notice of Independent Review Decision

DATE OF REVIEW: June 30, 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 at C3-C5

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: Upheld (Agree)

PATIENT CLINICAL HISTORY (SUMMARY):

According to the medical records, the patient sustained an industrial injury on xx/xx/xx. She has been treated with 36 physical therapy visits, trigger point injections, durable medical clinic, and previous cervical epidural steroid injections. The cervical epidural steroid injections were administered on April 22, 2002 and May 14, 2002.

A January 9, 2002 cervical spine MRI report includes an impression of evidence of disc space height loss at the C5-6 level with disc desiccation and anterior/posterior spondylitic changes. Posterior spondylitic ridging produces a 2-3 mm broad-based hard disk which touches but does not efface the cervical cord. There is also evidence for uncinete proliferative changes about the uncinete processes bilaterally narrowing the neural foramen at this level, left slightly greater than right. At the C4-5 level, there is convexity of the disc annulus complex compatible with a 1-2 mm annular bulge narrowing the subarachnoid space without touching or effacing the cervical cord. Minimal facet arthropathy changes are demonstrated about the articular facets bilaterally. An upper extremity electrodiagnostic study was conducted on April 11, 2002 and was found to be normal with no evidence of radiculopathy.

The records include a May 29, 2008 peer review report which renders a non-certification for an epidural steroid injection to the cervical spine at C3-C5. The report states that the patient was declared MMI on August 6, 2003 with 0% cervical impairment.

The April 2008 examination was reported to be without objective evidence of radiculopathy. The reviewer stated that it is almost 7 years from the date of injury. No diagnostic studies or interval history was provided.

A May 30, 2008 appeal letter was submitted. The report states that a cervical myelogram in the past revealed diminished

filling bilaterally at C5-6 with ventral defect at C4-5 and C6-7 with a partially calcified C5-6 disc herniation with spinal cord impingement. There is also left C6 nerve root impingement. The patient has been treated conservatively, but is gradually getting worse. When seen on May 22, 2008, she complained of increasing pain in the neck. A Medrol dose pack on April 24, 2008 helped only temporarily. Examination on May 22, 2008 revealed 5-/5 left biceps weakness as well as 4+/5 bilateral deltoid weakness. Cervical range of motion was reduced.

The case was again reviewed on June 5, 2008 with an adverse determination. The reviewer stated that there is no objective evidence of cervical radiculopathy via serial exams over time. The patient has completed a chronic pain management program and entrance to this program is predicated on the fact that all of the medical care has been exhausted. She was assigned at 0% whole person impairment of the cervical area, which would mean that there was no evidence of cervical radiculopathy. This was upheld per Decision and Order.

It should be noted that a May 22, 2002 report from the requesting physician states that the patient had two cervical epidural steroid injections. These did not help according to the report. It should also be noted that a December 30, 2002 report by the requesting physician states that the patient had facet injections in the past and epidural steroid injections. On both, she states that the pain was worse than the improvement.

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

The Official Disability Guidelines state that a criterion for proceeding with cervical epidural steroid injections is that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The most recent physical examination only reveals a very mild left biceps weakness in addition to symmetrical bilateral deltoid weakness. These findings would not conclusively suggest that the patient has current, active cervical radiculopathy. The most recent electrodiagnostic study was negative for evidence of cervical radiculopathy. In addition, as pointed out by the other reviewers, the patient was deemed to have a 0% whole person impairment regarding the cervical spine. This was apparently upheld per Decision and Order.

Most importantly, however, the Official Disability Guidelines state that repeat block should only be offered if there is significant pain relief for six to eight weeks. The medical records reflect that the patient did not have significant pain relief following previous cervical epidural steroid injections. In fact, it appears that the patient did not have any pain relief according to the May 22, 2002 report. Given these factors, the medical necessity of this request is not established. Therefore, my determination is to uphold the previous non-certifications of a cervical epidural steroid injection at C3-C5.

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

Official Disability Guidelines/Neck Chapter: Epidural Steroid Injection

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.