

SENT VIA EMAIL OR FAX ON
Nov/06/2008

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/10/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inject Spine C/T; Fluoroguide for Spine Inject; Epidurography

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Denial Letters 10/3/08 and 10/24/08
Records from Dr. 9/6/08 thru 9/30/08
OP Report 9/11/08
Electro-Diagnostic Test 9/24/08
MRI 8/25/08

PATIENT CLINICAL HISTORY SUMMARY

This is a lady that reportedly was injured on xx/xx/xx. She had neck pain and left arm pain reportedly 10/10. Her MRI (8/25) showed multiple level degenerative changes. The C6/7 region included a central disc herniation without compromising the left C7 nerve root or the neural foramen. She had a cervical epidural injection on 9/11. An EMG on 9/24, 2 weeks post injury, reported 3+ fibrillations in the left triceps (c7), but no other muscle abnormalities reported. Yet this was interpreted at C5-8 radiculopathy/ radiculitis. The 9/30 note that initially described a 15% reduction, but subsequently was revised to a 50% reduction in pain. In a

separate undated note, Dr. noted she was not taking much pain medication after the injection.

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

First, she had the MRI almost immediately after the injury. The EMG was done after the first cervical (interlaminar and not transforaminal) esi and showed one muscle involved, yet a multiple root level radiculopathy was identified. Dr. reported significant symptom relief to reduce most of the medications, but then described it as a 15% (revised to a 50%) reduction.

The value of lasting effects of a cervical epidural injection has been questioned by the American Academy of Neurology.

The criteria for ESIs is based upon the physical examination and the radiological and electrophysiological findings. First, Dr. examination 8/22/08 did not describe any neurological loss. It did state "Biceps, Triceps and Brachioradialis Reflexes were present and positive for pain." An asymmetrical reflex is key, and the Reviewer does not know what a positive one for pain is. The abnormal EMG was 2 weeks after the epidural injection and isolated to one muscle. The ODG is specific in that there should be at least a 50% reduction in pain and this should last for 6-8 weeks. Further no more than 2 ESIs should be given with a maximum of 4 per year. Dr. stated that there was only a 15% decrease in pain, and then described separately the reduction in the amount of medication used. The Reviewer initially suspected that there may have been a transcription error differentiating 15% and 50%. The 6-8 week interval was required by the ODG. This would be about this time per the report. Subsequent information was provided to the Reviewer and confirmed the error and that there was a 50% improvement and within the time frame requirements. Therefore, the request is medically necessary.

Dr. requested the use of fluoroscopy, and that is a necessity recognized in the ODG.

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) 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, 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-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)