

## Pure Resolutions Inc.

An Independent Review Organization  
1124 N. Fielder Road, #179, Arlington, TX 76012  
(817)349-6420 (phone)  
(512) 597-0650 (fax)

**DATE OF REVIEW:** November 10, 2008

**IRO CASE #:**

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

Medical necessity of transforaminal cervical steroid injection left C3/4

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

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)

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

Cervical spine, 04/20/03  
MRI cervical spine, 04/20/03  
Cervical myelogram, 05/11/04  
Post myelogram, 05/11/04  
MRI cervical spine, 07/15/05  
Office notes, Dr., 06/12/08, 07/10/08, 08/21/08, 10/09/08  
Cervical spine X-rays, 06/12/08  
Cervical myelogram, 07/07/08  
Post myelogram CT cervical spine, 07/07/08  
Operative report, Dr., 08/15/08  
Denial, 8/29/08, 09/15/08  
OD Guidelines

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

This is a xx year old male who underwent a C5-6 fusion, date not provided. The claimant continued to have neck pain and paresthesias. On 07/10/08, Dr. reviewed the CT myelogram and felt that the C5-6 level was solidly fused with spondylitic changes at C3-

4 and C6-7. Examination that day revealed strength 5/5 to the upper extremities, decreased sensation to pinprick and light touch to left C5, C6 and C7. The claimant underwent a cervical epidural steroid injection at C6-7 on 08/15/08 for no significant relief.

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

The request for C3-4 transforaminal epidural steroid injection cannot be considered reasonable or medically necessary. The ODG suggested that epidural steroid injections can be considered to determine the level of radicular pain where diagnostic imaging is ambiguous and/or to specifically evaluate the pain generator. In this particular case the C3-4 level is reportedly spondylitic but on CT myelogram does not describe significant neurocompression. Perhaps more notably is the fact that the sensory abnormalities are to the contralateral side of any reported neurocompression at C3-4 and not suggestive of pathology at C3-4 as the treating physician suggests that the sensory changes are at C5-6 and C7. While epidural steroid injections can be effective in determining the source of individuals pain complaints the records themselves do not provide a compelling case. The C3-4 is the level of concern. As such, when considering the inherent risks of these injections and whether or not they are likely to provide diagnostic value, this reviewer cannot suggest that they meet necessary evidence based criteria for proceeding based on the information available.

Official Disability Guidelines Treatment in Workers' Comp 2008 Updates, neck and upper back

**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)

