

**C-IRO, Inc.**  
**An Independent Review Organization**  
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Austin, TX 78726

Notice of Independent Review Decision

**DATE OF REVIEW: OCTOBER 17, 2008**

**IRO CASE #:**

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

Medical necessity for C5/6 epidural steroid injection.

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

MD, 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 C5/6 epidural steroid injection.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 09/02/08, 09/19/08  
ODG Guidelines and Treatment Guidelines  
Office notes, PA for Dr. 10/11/07, 01/04/08  
Nurse Case Manager consultant report, 11/01/07  
MRI lumbar spine, 01/02/08  
Office notes, Dr. 02/07/08, 03/21/08, 09/15/08  
Office notes, Dr. 05/12/08, 06/16/08, 07/08/08, 07/15/08, 07/29/08, 08/26/08  
MRI thoracic spine, 06/25/08  
MRI cervical spine, 07/09/08  
Office notes, Anesthesiology, 07/25/08, 08/05/08, 09/16/08  
Trigger point injection, 08/08/08

Fax authorization request, 08/27/08  
Physical therapy summary, 09/04/08  
Letter to Worker's Compensation, Dr. 09/04/08  
Tracking sheet, Dr. 10/01/08  
Disputed benefits notices, 03/07/08, 05/12/08, 06/13/08, 08/01/08, 08/18/08

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

The claimant is a female who injured her left shoulder on xx/xx/xx escorting a student to the office. A 01/02/08 MRI of the left shoulder was unremarkable. Dr. 's 05/12/08 office note stated the claimant had full neck range of motion, good movement of the upper extremities, and the thoracic spine was normal. The diagnosis was chronic myofascial, thoracic, and subscapular pain.

A 06/25/08 MRI of the thoracic spine was unremarkable. The 07/09/08 cervical MRI revealed C3-4 mild disc bulge, a C5-6 small central disc protrusion which mildly effaced the subarachnoid space, there was no cord deformity. Dr. performed a trigger point injection of the left rhomboid and a epidural injection at C7-T1 on 08/05/08, which reportedly gave little benefit. The diagnosis was Myofascitis.

Dr. in a 8/26/08 office note stated the claimant was seen by Dr. who felt the claimant did not have a shoulder problem and treatment was completely non surgical. The claimant's range of motion was good, and was not really having neck pain.

The claimant completed therapy on 09/04/08 and was discharged to a home exercise program. Eleven percent of the therapy goals had been met. Dr. examined the claimant on 09/15/08, the cervical range of motion was full at all planes but painful. Sensation and strength was intact. The diagnosis was chronic myofascial, thoracic, and subscapular pain, intervertebral disk disorder of the cervical spine, myofascial pain syndrome, and somatic dysfunction.

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

Review of records provided supports the claimant is a woman who strained her left shoulder on xx/xx/xx. Nurse case manager report on 11/01/07 noted the claimant was complaining of pain from her neck to her toes and that the accepted injury was a back injury.

MRI of the left shoulder was normal 01/02/08. She is complaining of pain at Dr. 02/07/08, 03/20/08 and treated with osteopathic manipulation. MRI thoracic spine was unremarkable 06/25/08. MRI of the cervical spine showed mild bulges at C3-4 and C5-6 with no cord deformity, no neuroforaminal narrowing, no nerve root impingement 07/09/08 and recommended epidural steroid injection at that time. They treated with her physical therapy, activity modification at work. Epidural steroid injection was performed 08/05/08. It was noted that the epidural gave no significant relief. Based on the failure to respond to the initial epidural steroid injection and the fact that there is no evidence of pure radiculopathy on objective physical examination and findings or diagnostic testing, the reviewer agrees with the previous adverse determinations that a repeat cervical epidural steroid injection C5-6 is not medically necessary. This decision is based on review of records provided, evidence based medicine and ODG guidelines. The MRI of

the shoulder is normal. MRI of the cervical spine shows a mild bulge, no neuroforaminal narrowing or central cord stenosis. There is no documentation of an abnormal EMG and NCS confirming radiculopathy of the upper extremities. The reviewer finds that medical necessity does not exist for C5/6 epidural steroid injection.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates. Neck, epidural steroid injections

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.

**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)