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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/17/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

C5/C6 Epidural Steroid Injection

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Peer review, denied 07/01/09

Peer review-imaging showed no spinal cord impingement or stenosis 07/15/09

MRI cervical spine 09/24/03

MRI scan left elbow-small joint effusion 09/24/06

MRI right shoulder 09/24/03

Office note Dr. 10/27/03, 01/26/04, 04/04/05, 05/15/05, 07/11/05, 07/22/05, 09/15/05, 11/17/05, 09/21/06, 04/11/07, 12/11/08, 01/05/09, 04/16/09

MRI cervical spine 04/22/05

Cervical spine two views 08/10/05

Cervical spine 10/09/06

Cervical myelogram CT 10/27/06

Cervical myelogram 01/05/09

Prescription 06/25/09

PATIENT CLINICAL HISTORY SUMMARY

This is a female who was status post anterior cervical discectomy and fusion C6-7 in July 2005 for reportedly good resolution of her preoperative symptoms. On 04/11/07, Dr. noted

solid fusion at C6-7 and no motion on flexion extension. On 12/11/08, the claimant reported worsening of her symptoms. The 01/05/09 cervical myelogram CT revealed a healed confluent C6-7 anterior cervical discectomy and fusion without stenosis. It was noted that compared to the previous study, there was progressive combined hard and soft disc protrusion at C5-6 which was 2-3 millimeter in thickness and asymmetric toward the left without spinal cord impingement or stenosis. Dr. evaluated the claimant on 01/05/09 and noted that the claimant had retrolisthesis and instability and increasing disc bulging at C5-6. The claimant noted that the previous injections did not help.

Impression was progressive worsening disc herniation at C5-6 with retrolisthesis of C5 on C6 solid fusion. On 04/16/09, Dr. noted that the electromyography showed bilateral C5 radiculopathy and left C7 radiculopathy. Examination appeared to be within normal limits. Dr. noted that the claimant had failed physical therapy and epidural steroid injection. On 06/25/09, Dr. recommended cervical epidural steroid injection C5-6.

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

The evidence based ODG criteria suggests that epidural steroid injections are indicated to reduce pain and inflammation in the process of facilitating an individual's recovery. They are typically recommended for individuals who have documented signs of radiculopathy and for whom conservative measures have failed. They are generally prescribed on an individual basis as there is no indication that a series of three epidurals would be either reasonable or medically necessary.

In this particular case, the imaging studies according to Dr. show a change at C5-6. That said, the CT myelogram suggested that although there is some progression of a disc protrusion at C5-6, there is no distinct neural foraminal compression and/or cord impingement.

Recent EMG's suggest bilateral C5 radiculopathy and also left C7 radiculopathy that does not correlate with the reported change at C5-6. While epidural steroid injections can be useful in helping determine the etiology of an individual's pain complaints, it is unclear that this injection is likely to be any more beneficial than those that had been done in the past without significant relief. As such, without further clinical information the request can neither be viewed as reasonable and/or medically necessary. The reviewer finds that medical necessity does not exist for C5/C6 Epidural Steroid Injection.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter neck and upper back, epidural steroid injection

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)