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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/25/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Epidural Steroid Injection C5-6

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

MD, Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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

Adverse Determination Letters, 12/15/08, 12/30/08

ODG Guidelines

Operative Reports, 5/23/06, 6/27/06, 2/18/98

Hospital Records, 5/23/06, 6/27/06

MRI, 8/15/05

MD, 9/27/05

PT Report, 7/23/08

Diary, 2/9/09, 12/8/08, 10/28/08, 9/30/08

EMG/NCV, 4/24/95

, 8/12/08, 6/6/06, 6/11/06, 7/11/06, 2/9/09, 12/8/08,

10/28/08, 9/30/08, 8/28/08, 12/17/08

PATIENT CLINICAL HISTORY SUMMARY

This man was injured in xxxx. He underwent a lumbar fusion in 1996 and an anterior C5/6

fusion in 1998. The current request involves the cervical region. He has been followed by Dr.. The notes from the past year describe ongoing pain in the upper extremities involving the ring and little fingers, more on the left than the right. The pain goes to the shoulder blades and the center of the back. Examinations described 4+ bilateral strength, symmetrical reflexes and normal sensation. Physical therapy notes from July 2008 describe arm pain, but no motor loss or atrophy. He had cervical epidural injections at C5/6 in May and June 2006. He reportedly had a 50% reduction in pain for a few weeks after the May injection and then had the second injection in June. The most recent MRI was from 2005. It showed severe C6/7 stenosis from osteophytes, stenosis at C7/T1 from the uncinat process, and the C5.6 fusion with uncovertebral arthropathy. A broad disc herniation and facet arthropathy narrowed the left C4/5 neural canal.

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

The ODG permits epidural injections for radicular pain “in a dermatomal distribution with corroborative findings of a radiculopathy.” The pain described here was along the C8/T1 dermatomes in the ring and little fingers and C7/8/T1 to the midline between the scapulae. This is not in the C5/6 region requested. Further, the ODG reports the relief to be transient. It cites the AAN review that did not support cervical ESIs for radicular pain. This man only had brief relief reported in 2006. Cervical ESIs require the documentation of a radiculopathy by physical examination with corroboration by imaging and/or electrodiagnostic studies. The MRI from 2005 is compatible with cervical radiculopathy at multiple levels, but there was no evidence of muscle wasting/atrophy, asymmetrical reflexes, etc. Although the claimant has a radicular pain pattern, the request for the injections is not for the same level. There is also no physical examination evidence, just subjective pain, of a radiculopathy and the multiple level MRI abnormalities. The reviewer finds that medical necessity does not exist for Cervical Epidural Steroid Injection C5-6.

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)