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Notice of Independent Review Decision

DATE OF REVIEW: 09/24/09

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical ESI

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- 06-17-08 Medical review and Medical Assessment from Dr.
- 07-14-08 Cervical MRI as read by Dr.
- 08-13-08 Pain Management follow-up office visit from Dr.
- 10-08-08 Pain Management follow-up office visit from Dr.
- 04-27-09 Clinical Encounter Summaries from Dr.
- 06-22-09 Medical report from Dr.
- 07-22-09 Pain Management, Letter of Medical Necessity from Dr.
- 07-10-09 Physician Adviser Report
- 07-10-09 HCN denial letter, unsigned
- 07-10-09 Letter of denial for cervical ESI
- 08-03-09 Appeal denial letter from Travelers
- 08-27-09 Request for IRO from the Claimant
- 09-01-09 Letter of denial for request for ESIs , resending letter of 7-10-09.
- 09-04-09 Confirmation of receipt of IRO Request, TDI
- 09-08-09 Notice of Assignment of IRO, TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a employee who sustained an industrial injury to the neck, right shoulder, both wrists and knees on xx/xx/xxxx when she tripped and fell near her work desk. The patient is described as 5' 5" and 172 pounds. Cervical MRI performed on May 8, 2008 revealed posterior disc protrusion at C3-4, C4-5, C5-6 and C6-7. At C3-4 and C4-5 the protrusions impinge upon the ventral margin of the cord without cord compression. EMG/NCV dated February 4, 2008 was interpreted as showing evidence of chronic bilateral C5-6 motor radiculopathy.

The patient attended a Required Medical Examination per request of the carrier on June 17, 2008. The patient was guarding her neck and reports she was administered a cervical epidural steroid injection (CESI) the previous day. She has been under the care of a number of providers and has been given diagnoses including, cervical strain with disc protrusions, upper extremity radiculopathy, right shoulder impingement syndrome, bilateral wrist sprain and bilateral knee sprain. She has had extensive conservative measures including PT and injections. She was declared MMI on December 5, 2006 by the designated doctor.

Opinions were provided regarding the appropriateness of the treatment. An updated cervical MRI was recommended. The patient is in her second series of epidural injections which are providing only about two weeks of relief. The right shoulder may be the pain generator and a diagnostic subacromial injection could be useful. She should see an orthopedic surgeon and a spine surgeon to determine whether surgery is necessary rather than continuing chronic pain treatments that have achieved very little results.

Updated cervical MRI was performed on July 24, 2008 and provided the impression: 1. Reversal of the usual lordotic curvature is seen. There is a severe disc extrusion and free fragment at C4-5 dissecting posterior to C4. The extruded disc and fragment measures 9.0 x 5.0 x 5.0 mm with flattening of the cervical cord. There is severe narrowing of the right neuroforamen. At C5-6 there is a 5.0 focal right disc protrusion which indents the adjacent thecal sac with mild narrowing of the right neuroforamen. At C6-7 there is a 4.0 mm disc herniation which indents the adjacent thecal sac with mild narrowing of the left neuroforamen.

The provider notes of August 13, 2008 discuss the MRI results. The problem discs appear to be C5-6 and C6-7. Her EMG shows a chronic C5-6 motor radiculopathy. She still has numbness in her right hand and tightness in her right forearm. She continues to work modified duties. Per imaging there are no rotator cuff tears. We will plan a shoulder injection for impingement. On October 8, 2008 the patient reports pain radiating intermittently into the right hand. She presents for a shoulder injection. She has no tenderness about the shoulder and she demonstrates full shoulder range of motion. Following shoulder injection, the patient noticed no difference in her pain pattern. She is not interested in neck surgery. She has had 2 CESI with 50-60% relief of neck and right arm pain. She will return in 6 months for possible repeat CESI.

The patient was reevaluated for possible surgery on April 27, 2009. The patient reports persisting neck and right arm pain which comes and goes. The pain radiates predominantly to the right trapezius and down over the right scapula. The patient is a smoker. The neurological examination is normal. Bilateral Hoffman's are equivocal. She is not interested in surgery at this time. CESI were briefly helpful but what she most feels beneficial were the trigger point injections.

The patient was provided an examination on June 22, 2009 for constant neck pain and right arm numbness. She is using Ibuprofen, Xanax, Verapamil, Allegra-S and Tizanadine. We plan cervical traction this visit and a CESI next visit. CESI were formally requested on July 22, 2009.

Request for CESI were considered in review on July 10, 2009 and recommended for non-certification. The patient had 2 CESI in 2008 with 50% relief after the initial injection and no result with the second injection. At the June 22, 2009 reevaluation the provider did not document a physical examination. Repeat injections should be based on continued objective documented pain and function response. Lacking documentation of current physical examination findings, the request was recommended for non-certification. A peer discussion was attempted but not realized. (The initial denial letter and non-determination review were resent to the provider on September 1, 2009.)

The provider requested reconsideration for CESI which was considered in review on August 3, 2009 with recommendation for non-certification. A peer discussion was attempted but not realized. Repeat CESI was denied with rationale that the request did not meet guideline requirements. The patient had 2 CESI in 2008 with 50% relief reported after the first, and no result reported after the second. At the current reevaluation the provider did not document a physical examination.

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

The patient has complaints of neck pain and right-sided radicular symptoms and neuroforaminal compression at C4-5 and C5-6 per MRI. However the patient does not desire neck surgery. She also has been diagnosed with right shoulder impingement. She is using ibuprofen 2400 mg daily and a muscle relaxant. Current recommendation is for cervical traction and a third CESI.

The patient was certified a CESI and right shoulder subacromial injection on March 12, 2008 for findings consistent with cervical radiculopathy and shoulder impingement. CESI was administered on April 9, 2009 at the right C5-6. Response to CESI was reported as 50% improvement (for about two weeks). A second CESI was administered on June 16, 2009 at right C7-T1 with response of 70-80% relief for about 1.5 weeks before pain returned (also reported as "no response").

Per ODG, in the therapeutic phase, repeat blocks should only be offered if there is at least 50% relief for 6-8 weeks. Repeat injections should be based on continued objective documented pain and function response. Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. Recommendation is usually for no more than 2 ESI injections.

As noted above, the patient had 2 CESI in 2008 with 50% relief after the initial injection and no result with the second injection (or, relief for 1.5 weeks). The duration of relief does not meet guideline criteria to establish the patient as a candidate for repeat epidural injections. ODG cites the American Academy of Neurology which recently concluded that epidural steroid injections may lead to an improvement in radicular lumbar 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. The lack of a current physical examination documenting radiculopathy in a dermatomal pattern as required by guidelines has been noted above. The patient appears to be a surgical candidate and CESI are not recommended as a long-term treatment but are recommended for temporary relief to delay a planned surgery. As noted by ODG, these treatments do not appear to decrease the rate of open surgery. The clinical findings do not establish the patient as a candidate for a third CESI. Therefore, my determination is to agree with the previous non-certification of the request for cervical epidural injection.

The IRO's decision is consistent with the following guidelines:

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

__X___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

The Official Disability Guidelines - Neck and Upper Back (09-09-2009): Epidural Steroid Injection:

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. Other reviews have reported moderate short-term and long-term evidence of success in managing cervical radiculopathy with interlaminar ESIs. Some have also reported moderate evidence of management of cervical nerve root pain using a transforaminal approach.) 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). There have been recent case reports of cerebellar infarct and brainstem herniation as well as spinal cord infarction after cervical transforaminal injection. Quadriparesis with a cervical ESI at C6-7 has also been noted and the American Society of Anesthesiologists Closed Claims Project database revealed 9 deaths or cases of brain injury after cervical ESI (1970-1999). These reports were in contrast to a retrospective review of 1,036 injections that showed that there were no catastrophic complications with the procedure. 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. 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. 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. W e 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.