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Notice of Independent Review Decision

DATE OF REVIEW: 10/05/09

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 C7-T1

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

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 02-19-09 Pain Diagram with pain rating from Dr.
- o 02-19-09 Medical report from Dr.
- o 06-08-09 Lab report from Laboratories
- o 06-08-09 Pain Diagram with pain rating from Dr.
- o 06-08-09 Medical report from Dr.
- o 07-20-09 EMG report from Dr.
- o 08-03-09 Pain Diagram with pain rating from Dr.
- o 08-03-09 Medical report from Dr.
- o 08-17-09 Medical report from Dr.
- o 08-17-09 Fax sheet - Pre-authorization request from Dr.
- o 08-24-09 Pre-Authorization request denial from Dr.
- o 08-24-09 Letter of Decision for non-certification CESI from /
- o 09-02-09 Appeal letter from Dr.
- o 09-18-09 Request for IRO from the Claimant
- o 09-21-09 Confirmation of Receipt of IRO
- o 09-22-09 Case Assignment of IRO from TDI
- o 09-07-09 Denial of appeal for CESI C7-T1 from Dr.
- o 09-08-09 Letter of Decision for non-certification, appeal, CESI from

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a xx-year-old employee who sustained an industrial injury to the cervical spine on xx/xx/xx. She is status post 3 neck surgeries including ACF at C3-4, C4-5, C5-6 and C6-7 and is followed at a multidisciplinary pain treatment facility with a diagnosis of left cervical radicular syndrome, post laminectomy syndrome,

osteoporosis with rib fractures August 2007, chronic pain and depression. The patient is described as 5' 7" and 109 pounds. She smokes 1 pack of cigarettes daily.

When reevaluated on February 2, 2009 the patient reports a pain level of 4/10. Moderate muscle tenderness is noted throughout the cervical and upper back regions. Cervical motion is restricted and there is pain noted with motions. Strength deficits are noted in the left biceps and triceps and grip of +4/5. Radicular pain is not noted. Sensation and reflexes are intact. Her mood and affect appear normal. She will continue current medications: Lortab, Celebrex, Robaxin, Protonix. Another physician is prescribing Cymbalta, Premarin and Prevacid. She will follow-up with her private physician regarding osteoporosis and weight loss. Return in 90 days.

At reevaluation of June 8, 2009 the patient reports some increase in pain and sleep difficulty. She reports pain ranging from 3-8/10. She now complains of right-sided neck pain of 2-3 months duration. The patient's past health history notes: asthma, chronic sinusitis, hearing loss, GERD, psoriasis, carpal tunnel syndrome, CRPS, entrapped nerve, epilepsy, chronic anxiety and depression with no previous non-surgical hospitalizations. Examination notes right-sided neck pain without radicular signs or symptoms. Left and right biceps and triceps strength are +4/5. Right and left wrist extension and flexion strength is -4/5. Plan includes, cervical and bilateral upper extremity EMG/NCV for increasing right upper extremity greater than left upper extremity symptoms.

The patient underwent urine testing and blood chemistry on June 8, 2009. Urine testing showed results consistent with the patient's medications. Blood work showed low blood glucose.

Bilateral upper extremity EMG conducted on July 20, 2009 was provided impression: EMG abnormalities suggest a bilateral C4 radiculopathy and a C5 and C6 radiculopathy on the left.

The patient returned for reevaluation on August 3, 2009 reporting pain ranging from 5-9/10. She reports a need for increased medication and increased limitation in daily activities. She reports persisting right-sided neck pain. The patient's weight is currently 110 pounds. Examination notes right-sided neck pain without radicular pain. Strength deficits are unchanged from the prior exam. Reflexes are symmetrical. L'Hermitte's is negative with cervical range of motion. Cervical compression is negative. Plan includes, cervical ESI at C7-T1 for a flare-up with 3 sessions of post injection PT. Trial of Pristiq and trial of Nexium.

Pre-authorization was requested on August 17, 2009 for cervical epidural injection C7-T1. The CPT codes requested include codes for manual therapy and ultrasound.

The patient was reevaluated on August 17, 2009 for posterior neck and trapezius pain, right greater than left. She reports a pain level of 7/10. The exam is essentially unchanged. Epidural injection is again recommended.

Request for epidural injection at C7-T1 was considered in review on August 24, 2009 and recommended for non-certification. A peer discussion was attempted but not realized. The medical records noted tenderness and restricted cervical motion and there was mention of some upper extremity weakness with muscle strength in various muscle groups with strength at mostly 4+/5. Otherwise physical exam findings were unremarkable. No clear rationale was provided as to why cervical ESI is being requested for an old injury. Additionally prior ESI and the results were not clarified. Also, nerve studies have not revealed any specific radicular component occurring at the C7-T1 region.

Non-certification was appealed by the provider on September 2, 2009: The International Spine Injection Society standards (attached) note that the safest injection level is C7-T1 to avoid spinal cord injury along with use of a 10 ml volume so that the entire cervical spine is treated. The records do not clarify if prior ESI have been administered. Please reconsider and overturn the denial.

Request for appeal cervical ESI C7-T1 was considered for review on September 8, 2009 and recommended for non-certification with rationale that ODG requires that radiculopathy be documented and corroborated by imaging studies and/or electrodiagnostic testing. Objective findings need to be present on examination. Objective findings were documented and the EMG showed evidence of radiculopathy. However, radiculopathy was documented at levels that were higher than the level of request. The specific request is described in the review as: Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s).

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

The patient is status post 3 neck surgeries including ACF at C3-4, C4-5, C5-6 and C6-7 and is followed at a multidisciplinary pain treatment facility with a diagnosis of left cervical radicular syndrome, post laminectomy syndrome, osteoporosis with rib fractures August 2007, chronic pain and depression. The patient is described as 5' 7" and 109 pounds. She smokes 1 pack of cigarettes daily and her health history includes such conditions as asthma, chronic sinusitis, hearing loss, GERD, psoriasis, carpal tunnel syndrome, CRPS, entrapped nerve, epilepsy, chronic anxiety and depression with no previous non-surgical hospitalizations. She is reporting increased neck pain.

Per ODG, in consideration of ESI, 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. The medical

records note, right-sided neck pain without radicular pain. Strength deficits of bilateral biceps and triceps strength of +4/5 and right and left wrist extension and flexion strength of -4/5. Reflexes are normal and there is a negative L'Hermitte's with cervical range of motion. Cervical compression is negative for radiating symptoms. EMG abnormalities suggest a bilateral C4 radiculopathy and a C5 and C6 radiculopathy on the left.

The injection as requested is described as, injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s). There does not appear to be a plan for guided fluoroscopy.

In this case, the patient is reported not to have radicular symptoms and cervical compression is negative for radiating symptoms, although recent EMG abnormalities suggest a bilateral C4 radiculopathy and a C5 and C6 radiculopathy on the left. EMG findings are more diffuse in nature, and primarily involve the paraspinal muscles which are less diagnostic in nature. Further, the patient's pain diagram notes primarily axial symptoms, without radicular radiation into the upper extremity. In addition, the patient's alleged weakness is also noted to be diffuse, and bilateral in nature. Overall, there is weak support for an acute radiculopathy at this time that would necessitate interventional epidural procedures.

Lastly, the patient's injury is over 13 years post date of injury. There is no documentation of conservative treatments attempted for her report of increased neck pain. She is continuing her current medications, however, no treatment has been documented. Per criteria #2: exercises, physical methods, NSAIDs and muscle relaxants should be tried prior to considering ESIs. Given the patient's health history, lifestyle education would appear to be the best long-term treatment for this patient. It would not be prudent to rush to interventional pain management treatments for a patient 13 years post injury.

Therefore, my recommendation is to agree with the previous recommendation for non-certification of the request for cervical ESI C7-T1.

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 (9-9-2009) 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, 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.