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Notice of Independent Review Decision

DATE OF REVIEW: 9/15/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical ESI C6-C7 with fluoroscopy

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

Certified by the American Board of Anesthesiology with subspecialty certification in Pain Medicine

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	723.1	77003	Upheld
		Prospective	723.1	62310	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Letter to IRO dated 9/7/09

Physician notes/evaluations dated 8/16/09, 6/25/09, 5/4/09, 4/9/09, 2/20/09, 2/10/09, 1/29/08

X-rays/MRI reports dated 12/14/06, 1/10/07

Operative Report dated 1/18/08, 1/23/09
Official Disability Guidelines cited but not provided-Spine Treatment Guideline, Criteria
for epidural steroid injection

PATIENT CLINICAL HISTORY:

The xx-year-old patient sustained an injury on xx/xx/xx when trying to put a patient in bed and felt a pull in her neck on the right side. The patient was initially seen at the emergency room and diagnosed with mid back pain. She later complained of headaches and neck pain. The patient was treated conservatively.

MRI of the cervical spine from 12/14/06 was noted to reveal minimal degenerative changes at C5-6 with no spinal or neural foraminal stenosis. Plain films of the cervical spine showed some convex scoliosis versus muscle spasm and disc narrowing C5-6. Nerve conduction studies performed on 02/20/07 revealed evidence of bilateral carpal tunnel syndrome, with no evidence of cervical radiculopathy, brachial plexopathy, peripheral neuropathy or myopathy. The patient underwent cervical discogram on 01/18/08 which reported positive concordant pain at C5-6 and C6-7. Post discogram CT reported a small central left lateral disc bulge at C5-6 unchanged from previous MRI.

The patient was evaluated on 01/29/08 and the diagnosis is reported as cervical strain. The physician determined that the patient reached MMI as of 01/29/08, and that any other treatment was not needed. The physician assessed the patient at 5 percent whole person impairment, and noted that the patient could return to light duty. The physician also noted that the patient had evidence of Waddell's signs.

The patient underwent cervical facet joint injections at C5-6 and C6-7 bilaterally on 01/23/09. Progress note dated 02/10/09 reported the patient had minimal improvement with cervical facet joint injections. The physician noted that the patient has had a course of physical therapy that was helpful, and she continues to perform therapy exercises at home.

The patient was seen on 02/20/09 for reevaluation of neck and upper extremity pain. It was noted that the patient did not experience any significant relief with facet blocks, and that her neck pain seems to be primarily discogenic, and recommended the patient to undergo cervical myelogram with CT scan.

Progress note dated 04/09/09 reported the patient continues with chief complaint of neck pain. On examination there was decreased cervical range of motion, with mild to moderate paraspinal tenderness around C5, C6, C7. The physician noted that the patient is not a candidate for surgery, and recommended cervical epidural steroid injection.

Physical examination on 05/04/09 reported limited range of motion of the cervical spine in extension, flexion, lateral bending and rotation which elicited some increased pain to the neck and bilateral posterior shoulders. There was tenderness over the suboccipital regions and cervical trapezial areas. There was tenderness over the facets C4-C7. The patient was also noted to have myofascial and trigger point tenderness to the right trapezial musculature. Muscle strength in the upper extremities was graded 5/5

bilaterally. Sensation was intact to light touch over the bilateral upper extremities. Provocative testing reported negative Spurling's compression maneuver.

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

In the Reviewer's opinion, cervical ESI C6-7 with fluoroscopy for this patient is not medically necessary. The patient is noted to have sustained a lifting injury in xx/xx. Per ODG guidelines, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The Reviewer noted that the patient has no clinical findings of cervical radiculopathy, no electrodiagnostic studies indicative of cervical radiculopathy, and no clear neural compressive pathology of the cervical spine on MRI. Cervical discogram reportedly was positive at C5-6 and C6-7, but there is no negative control level to validate findings on discography. Given the lack of evidence of radiculopathy on clinical examination or on EMG, medical necessity is not established for the proposed cervical ESI C6-7 with fluoroscopy.

Reference: ODG

Epidural steroid injection (ESI)	<p>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.</p> <p>Criteria for the use of Epidural steroid injections, therapeutic: <i>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.</i></p> <p>(1) Radiculopathy must be documented by physical examination <u>and</u> corroborated by imaging studies and/or electrodiagnostic testing.</p>
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	<p>(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).</p> <p>(3) Injections should be performed using fluoroscopy (live x-ray) for guidance</p> <p>(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.</p> <p>(5) No more than two nerve root levels should be injected using transforaminal blocks.</p> <p>(6) No more than one interlaminar level should be injected at one session.</p> <p>(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.</p> <p>(8) Repeat injections should be based on continued objective documented pain and function response.</p> <p>(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.</p> <p>(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.</p> <p>(11) Cervical and lumbar epidural steroid injection should not be performed on the same day.</p> <p>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:</p> <p>(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;</p> <p>(2) To help to determine pain generators when there is evidence of multi-level nerve root compression;</p> <p>(3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g. dermatomal distribution) but imaging studies are inconclusive;</p> <p>(4) To help to identify the origin of pain in patients who have had previous spinal surgery.</p>
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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)**