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Notice of Independent Review Decision

DATE OF REVIEW: MARCH 12, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical ESI with fluoroscopy.

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

American Board of Physical Medicine and Rehabilitation
Fellow, American Academy of Disability Evaluating Physicians

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

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- 02/26/10

- M.D., P.A., 06/30/09
- M.D., 11/30/09, 01/14/10
- 01/13/10
- 10/08/08
- TWCC Statement for Pharmacy Services, 09/28/08, 10/08/08, 11/02/08, 11/30/08, 12/21/08, 01/11/09, 01/14/09, 02/08/09, 02/15/09, 03/04/09, 04/05/09, 04/26/09, 04/29/09, 05/20/09, 06/14/09, 06/17/09

Medical records from the Requestor/Provider include:

- Orthopedic and Center, 03/28/07
- 09/18/07
- Solutions, 09/18/07
- 09/21/07
- Office of Injured Employee Counsel, 04/17/08
- M.D., 11/30/09, 01/14/10
- 01/15/10

PATIENT CLINICAL HISTORY:

This female was originally injured in xx/xx. There is no information regarding the details of her original injury or mechanisms of such. She reportedly had a right shoulder rotator cuff repair in February of 2003, with a second right shoulder surgery in September of 2006 due to a recurrent rotator cuff tear.

The patient underwent a C5-6 cervical anterior fusion on May 5, 2005.

The records indicate that the patient has a history of a re-injury with a 3.7 mm separation of her torn rotator cuff on MRI in 2007. The MRI scan also reportedly demonstrated old plating at C5-6 with disc ruptures above and below that level. M.D., an orthopedic surgeon, had recommended a discogram at that time and discussed repair of the rotator cuff and “probably” the cervical spine as well.

It appears, however, from the records provided, which are minimal, that the patient re-injured her shoulder while incarcerated and using her arm getting in and out of the upper bunk of her bed repeatedly. It does not appear that the carrier accepted the right shoulder and neck as causally related to the original injury.

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

The patient does not meet 2010 ODG Criteria for epidural steroid injections. The records provided do not give any indication that the patient has clinical evidence of a cervical radiculopathy.

The progress notes indicate the patient has constant moderate-to-severe neck, shoulder, right arm, wrist and hand pain, back and left thigh pain. However, on the pain diagram included in the records submitted, the patient only referenced neck and shoulder pain.

The examination documented by the treating physician does not indicate any neurologic deficits in reference to the upper extremities which would evidence a cervical radiculopathy. Motor strength, sensation and reflexes are listed as intact.

There is additionally no evidence in the records provided that the patient has had any significant sustained relief from this treatment in the past, as required per ODG Guidelines.

The records dated November 30, 2009, indicate that the patient has previously had several cervical epidural steroid injections with symptom relief for “a few weeks.” ODG Guidelines, as listed below, require documentation of at least 50% pain relief for six to eight weeks duration; however again, this would be in the presence of a cervical radiculopathy, which there is no clear documentation of in this patient’s case.

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
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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](#)) ([Benyamin, 2009](#)) 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- 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)