Notice of Independent Review Decision

DATE OF REVIEW: 01/28/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical Epidural Steroid Injection at C5-C6

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

Board Certified in Anesthesiology with Certificate of Added Qualifications in Pain Medicine

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Cervical Epidural Steroid Injection at C5-C6 – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was allegedly injured on xx/xx/xx when, while sitting on a chair, the chair broke, causing her to fall, landing heavily on her buttocks. She had a significant prior medical history of neck surgery including posterior cervical laminectomy and foraminotomy at C6-C7 and C7-T1 on 03/08/08, as well as anterior cervical fusion at C4-C5.

The patient was initially evaluated by Dr. on 06/16/09, complaining of neck pain radiating down the right arm to the elbow. Dr. ordered a lumbar MRI scan, which demonstrated a 1-2 mm left C3-C4 disc protrusion, a 1 mm C5-C6 protrusion, and a 2 mm right C6-C7 protrusion with severe right and moderate left foraminal stenosis. She then completed eight sessions of physical therapy with little to no benefit.

A cervical myelogram/CT scan was performed on 01/19/10, demonstrating 2-3 mm anterior epidural impressions at C3-C4, C5-C6, and C6-C7. All the nerve root sleeves were said to fill "relatively normally." The CT scan demonstrated solid C4-C5 anterior fusion, and 2-3 mm broad-based posterior disc protrusions were noted at C3-C4, C5-C6, C6-C7, and C7-T1.

Electrodiagnostic studies were performed by Dr. on 03/30/10, demonstrating evidence of chronic bilateral C7 nerve root irritation.

An Independent Medical Examination was then performed by Dr. on 07/19/10, who stated that the extent of the patient's xx/xx/xx injury included dislodgement of the prior cervical fusion hardware and bilateral C7 radiculopathy.

A Required Medical Examination was then performed by Dr. on 08/30/10 who noted the patient was still working and taking only ibuprofen and Darvocet. Dr. noted she had undergone a Designated Doctor Evaluation with Dr. on 10/15/09, at which time she was stated to be at Maximum Medical Improvement (MMI) with a 0% whole person impairment rating. Dr. stated the patient had cervical strain and chest contusion, both resolved, as a result of the work injury, as well as signs of symptom magnification. He also noted the patient's pre-existing degenerative changes at multiple levels in the cervical spine. In his opinion, the compensable injury did not extend to include a diagnosis of cervical fusion hardware dislodgement, as he stated the cervical fusion hardware was not actually dislodged and that the findings of radiculopathy and the hardware were solely related to her pre-existing condition and surgery before the work injury. He stated the patient's degenerative changes and hypertrophic changes at a number of levels in the cervical spine were due to ordinary disease of life and stated the patient was, in fact, at MMI as of 10/15/09, awarding her a 5% whole person impairment rating. He recommended against the proposed facet cervical facet injections.

The patient was then referred to Dr. for evaluation on 11/03/10 for evaluation of neck pain radiating into both shoulders and headaches with a 10/10 pain level. Physical examination demonstrated normal cervical range of motion, normal motor and sensory examination, and normal reflexes in the upper extremities bilaterally. Despite this completely normal physical examination, Dr. recommended and performed a cervical epidural catheter infusion of steroids on 11/16/10.

The patient returned to Dr. for follow up on 11/29/10 who noted that she had "15-20% relief" so far. Physical examination still documented no abnormalities and normal motor and sensory exam. Dr. then recommended a second cervical epidural steroid injection.

Two separate physician advisers reviewed the request, both recommending non-authorization of the request, citing ODG Guidelines. Both reviewers found that the patient did not meet ODG criteria for a second epidural steroid injection, which required that a repeat epidural steroid injection "should only be offered if there is at least 50% pain relief for six to eight weeks after the first injection.

On 12/29/10 the patient returned to Dr. with "quite severe" pain. Physical examination, however, remained totally normal.

On 01/05/11 the patient returned to Dr. stating that the OxyContin that he provided her made her very nauseated. She still complained of "pain in her neck" and had an entirely normal physical examination. The claimant was started on Methadone.

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

ODG Guidelines are quite clear regarding the medical necessity for cervical epidural steroid injections. First, the guidelines clearly indicate that epidural steroid injections are only medically reasonable and necessary if a patient has pain complaints and physical examination findings of radiculopathy consistent with imaging and/or electrodiagnostic studies. In this case, the distribution of the patient's pain complaints were not consistent with the alleged electrodiagnostic evidence of C7 radiculopathy, and the physical examination documented by Dr. clearly did not demonstrate any findings of radiculopathy. In fact, the physical examinations documented by Dr. have consistently been totally normal with no evidence of neurologic deficits whatsoever. Therefore, the patient did not meet ODG criteria for the initial epidural steroid injection performed by Dr. Secondly, the ODG Guidelines clearly state that a patient needs to have at least 50% relief of pain for six to eight weeks following an initial epidural steroid injection to justify doing a second epidural steroid injection. In this case, the patient did not have more than 15% or 20% relief two weeks following the initial epidural steroid injection. Therefore, the patient clearly does not meet ODG Treatment Guidelines criteria for a repeat epidural steroid injection. The recommendations of the two physician advisers for non-authorization of the request for a second epidural steroid injection are, therefore, upheld as the requested procedure is not medically reasonable or necessary, according to ODG Treatment Guidelines, for treatment of the claimant's work injury of xx/xx/xx.

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)**
- ☐ **AMA GUIDES 5TH EDITION**