

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 1/25/2011
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Epidural Steroid Injection (62310; J1030)

QUALIFICATIONS OF THE REVIEWER:

Orthopaedic Surgery, Surgery Trauma

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)

Cervical Epidural Steroid Injection (62310; J1030) Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Review of case assignment by dated 01/05/2011
2. IRO request form by author unknown dated 01/04/2011
3. Request for a review by author unknown dated 01/03/2011
4. Letter by LVN dated 12/30/2010
5. Letter by LVN dated 12/13/2010
6. Letter by dated 1/7/2011
7. Fax page dated 1/5/2011
8. Case assignment by dated 1/5/2011
9. Independent review organization by Author unknown, dated 1/4/2011
10. Review organization by Author unknown, dated 1/3/2011
11. Letter by dated 12/30/2010
12. Letter by dated 12/13/2010
13. Disability duration guidelines dated 11/29/2010
14. Encounter note by MD, dated 11/2/2010 to 12/22/2010
15. Cervical epidural steroid injection by MD, dated 1/24/2010
16. Clinical note dated unknown
17. Epidural steroid injection dated unknown
18. Medication history dated unknown

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

male. He was injured when he fell out of a bucket on top of a forklift and a heavy palette fell over him. He had previous cervical epidural steroid injection (ESI) with 30% relief and trigger point injections. The side or level of ESI not provided. He had a previous C4-6 fusion in 2008 and a previous L3-4 microdiscectomy and sacroiliac injections. CT of the cervical spine 11/8/10 indicates aforementioned surgery; scattered levels of facet hypertrophy with neural foraminal encroachment, worst at left C4-5. There was mild disc bulge C3-4 and C6-7. He has had physical therapy for 9 visits for his cervical spine with D/C 10/18/10. He also had a TENS unit, response not documented. The request is for a repeat cervical ESI.

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

The injured employee history is above. The physical exam notes provided for his cervical spine from 11/2/10; 11/11/10; 12/7/10 and 12/22/10 do not document any evidence of a cervical radiculopathy.

According to ODG criteria, Chapter on Epidural Steroid Injections, they are recommended as an option in radicular pain. This IE has no documented evidence of a cervical radiculopathy.

Below is information on radiculopathy:

Radiculopathy by nerve level:

-C5 radiculopathy

-Weakness: shoulder abduction

-Test: Have patients hold their shoulders in abduction, against downward force by the examiner.

-C6 radiculopathy

-Weakness: elbow flexion, wrist extension

-Test: Have patients lift their arm against resistance by the examiner.

-C7 radiculopathy

-Weakness: elbow extension, wrist flexion

-Test: Have patients push with their arm away from their chest against resistance by the examiner.

- C8 radiculopathy

-Weakness: thumb extension, wrist ulnar deviation

-Test: Have the patients hold their extended fingers together against the examiner's attempts to open the fingers.

Sensory

-On sensory examination, patients with a clear-cut radiculopathy should demonstrate a decrease in or loss of sensation in a dermatomal distribution.

-In addition, patients with radiculopathy may have hyperesthesia to light touch and pin-prick examination.

-The sensory examination can be quite subjective because it requires a response by the patient.

Deep tendon reflexes

-The deep tendon reflexes—or, more properly, muscle stretch reflexes, because the reflex occurs after a muscle is stretched (most commonly by tapping its distal tendon)—are helpful in the evaluation of patients who present with limb symptoms that are suggestive of a radiculopathy. The examiner must position the limb properly when obtaining these reflexes, and the patient needs to be as relaxed as possible. Any grade of reflex can be normal, so asymmetry of the reflexes is most helpful finding.

-The biceps brachii reflex is obtained by tapping the distal tendon in the antecubital fossa. This reflex occurs at the C5-C6 level.

-The brachioradialis reflex is obtained by tapping the radial aspect of the wrist. It is also a C5-C6 reflex

-The triceps reflex can be obtained by tapping the distal tendon at the posterior aspect of the elbow, with the elbow relaxed at about 90° of flexion. This tests the C7-C8 nerve roots.

-The pronator reflex can be helpful in differentiating C6 and C7 nerve root problems. If this reflex is abnormal in conjunction with an abnormal triceps reflex, then the level of involvement is more likely to be C7. The pronator reflex is performed by tapping the volar aspect of the distal radius with the forearm in a neutral position and the elbow flexed. This results in a stretch of the pronator teres, resulting in a reflex pronation.

This IE also does not meet the ODG criteria of at least 50% pain relief with his previous injection. This IE had only 30% reduction in his symptoms. In addition, there was not the level or side documented. ODG criteria state that series of three or multiple ESI's not recommended.

If the IE truly did have relief with the ESI, that should be reflected in the medical records with a decrease in pain medication. That was not documented.

Overall, the IE doesn't meet ODG criteria for a cervical ESI. There is no documented radiculopathy or concordance between radiographic and clinical findings.

The recommendation is to uphold the previous denial.

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)

Manchikanti L, Cash KA, Pampati V, Wargo BW, Malla Y. Cervical epidural injections in chronic discogenic neck pain without disc herniation or radiculitis: preliminary results of a randomized, double-blind, controlled trial. Pain Physician. 2010 Jul;13(4):E265-78.