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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 01/11/2011

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) Doctor, 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 Epidural Steroid Injection - C7, 62310, 77003, 991441

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

Patient Clinical History [Summary]:

According to the medical records and prior reviews the patient is a female who sustained an industrial injury to the cervical spine on xx/xx/xx. The patient's history included a neck surgery of 15 years prior.

Co-morbid conditions include, history of congestive heart failure, multiple cervical surgeries including a fusion at C4-6 in 1995, asthma, high blood pressure, GERD, Cushing Syndrome, obesity and tobacco abuse.

Cervical x-rays taken March 5, 2008 showed surgical changes and degenerative disc disease. There was seen a prior anterior fusion C4-5. There was loss of disc height at the C7-T1 disc.

The patient was examined on March 11, 2008 for neck pain. She is very obese. She was. She had a cervical fracture years prior in a MVA and underwent ACDF. She recovered and returned to work. She does smoke cigarettes. X-rays show fusion C4-6, four screws and a six hole anterior plate. The fusion appears solid.

Neurological studies were performed on March 18, 2008. Sensation was intact bilaterally to light touch and pinprick. Giveway motor weakness was seen in the right deltoid, biceps and triceps along with some mild weakness in the APN on the right hand. The nerve studies showed evidence of bilateral carpal tunnel syndrome, more significant on the right and no clear evidence of radiculopathy on the EMG.

X-rays taken May 27, 2008 showed operative fusion at C4-5 and C5-6. Fusion at C6-7 and effective fusion at C7-T1 - the lower level is certainly degenerative in nature. No motion or subluxations.

Cervical MRI performed March 28, 2008 showed postsurgical changes status post anterior and posterior fusion spanning C4 through C6 with artifact degrading quality. Persistent reversed lordosis. Right greater than left neuroforaminal narrowing at C2-3 secondary to facet arthropathy. Mild spinal stenosis C3-4 with bilateral neuroforaminal narrowing at this level. The C6-7 neuroforamina are better visualized and do not appear to be narrowed as they did on the prior study. Bilateral neuroforaminal narrowing at C7-T1. Probable old C7 fracture. No new abnormalities.

The patient was reevaluated on March 31, 2008 for neck, right shoulder and right arm pain. She is wearing a sling. Nerve studies were reviewed and showed evidence of right CTS right and left, severe on the right, moderate on the left. Cervical radiculopathy was ruled out. Her husband says she has moaning pain at night, but she appears to have a strain and recommendation is for PT. A volar wrist splint was provided.

The patient was assessed in PT on April 14, 2008. Motion was very limited and guarded. Strength was moderate to severe with no myotomal or peripheral nerve pattern and there was inconsistent grip strength on the right. Reflexes were normal and Hoffman's negative.

At an initial examination of April 21, 2008 the patient was about to initiate PT. She was using a volar wrist splint. It was not felt the MRI or nerve studies had shown radiculopathy. Imaging was recommended to assess for a rotator cuff tear. Right shoulder MRI of April 23, 2008 showed mild supraspinatus tendonitis and mild AC arthropathy. By May 13, 2008 the patient had completed PT for her right shoulder. She still had right arm weakness and numbness. She attended additional PT. Treatment at this time was for her right shoulder and carpal tunnel syndrome, not for the neck.

Right shoulder MRI of April 23, 2008 was reviewed on April 28, 2008. There was mild bursitis and tendinosis and mild AC joint arthritis. Assessment is subacromial bursitis, acute cervical sprain, CTS and shoulder sprain.

On May 13, 2008 the patient reported some benefit with PT for the right shoulder. However, she can only abduct to 90 degrees due to pain. She reports the volar splint helps the CTS while worn. Examination showed shoulder crepitus, limited motion and 4/5 weakness of abduction. She has some tremor that is not related to her work injury. She has pre-existing neck disorder and MRI showed no changes - so this pre-existing condition does not appear to have been aggravated or exacerbated by her work injury.

The patient was examined by a new secondary provider on May 20, 2008. Examination noted sensory deficit in the right C6 distribution and some generalized muscle weakness about the neck. Cervical compression test was positive. Medication would be adjusted and an opioid agreement signed.

On May 20, 2008 the patient's primary provider noted she is being treated primarily for her shoulder and CTS, and secondarily for her neck. Her shoulder condition is not related to any pre-existing conditions.

Cervical x-rays taken May 27, 2008 showed operative bone fusion at C4-5 and C5-6 levels. Fusion is also present at C6-7 and effective fusion is present at C7-T1 - degenerative in nature certainly.

On June 3, 2008 the provider noted that 5 weeks of therapy had only increased her neck and arm symptoms. Recommendation was for myelogram.

On July 1, 2008 medications were listed as Neurontin, Norco, Zanaflex, Amitriptyline, Celebrex, Effexor, Estratest, Fluticasone Propionate, Furosemide, Lyrica (Mobic and Vicodin were stopped). The examination findings remain unchanged throughout the many progress reports.

A Designated Doctor Examination was conducted on July 28, 2008. Despite unchanged MRI and somewhat benign EMG for the neck, she holds her head in an unusual position to keep her pain managed and has difficulty moving her neck. She had been seen in pain management for about three weeks and a myelogram has been recommended. She smokes one-half pack daily. On examination, Tinel's and Phalen's are negative at the wrist, reflexes are symmetric and distal strength is maintained in the hands. Cervical ROM is quite restricted due mechanical block and soft tissue spasm. Diagnosis is status post C4 through C6 fusion 15 years (non-compensable), cervical radiculopathy C6 versus C7 by clinical localization and minor age related rotator cuff changes as per MRI of doubtful clinical significance. The patient would be MMI by the end of October 2008. She would attempt return to work and undergo additional imaging.

On August 12, 2008 the provider noted neck pain now radiates to the anterior neck affecting swallowing abilities. Myelogram is

pending. On October 7, 2008 myelogram is still pending.

Cervical myelogram performed November 13, 2008 showed solid anterior cervical fusion C4-5. 5% spondylolisthesis C2 relative to C3 without cord deformity or nerve root compression. There was indication of left C6-7 foraminal narrowing.

Cervical CT post myelogram performed November 13, 2008 showed anterior plate and screws to be in place at C4-5-6 and a strut graft from C4-7. There is a corpectomy at C7, with a defect in the inferior endplate. The fusion appears to be solid from C4-7. However, the spur directed inferiorly with near complete loss of disc height at C7-T1 is associated with kyphosis at C7 (moderate) as well as wedging of C7 (65% loss of height). While this is not a typical pseudoarthrosis, the amount of disc degenerative change, kyphosis and wedging is thought likely to be a pain generator at C7-T1.

On January 13, 2009 the provider noted marked increased weakness and numbness in the right arm/hand of several weeks duration. She would like to see a surgeon.

The patient was examined by a neurosurgeon on January 23, 2009. She has radiation of pain down both arms to all the fingers and to the left jaw. Her average pain is 7-8/10. She reports numbness, weakness and headaches. She has tried PT, NSAIDs and narcotic analgesics. X-rays show possible loosening of the anterior screws. MRI shows possible spondylosis C6-7, but is obscured by artifact. Her imaging studies show possible pseudoarthrosis of the prior surgery. Recommendation is for CT myelogram and EMG.

Nerve studies performed February 4, 2009 showed bilateral carpal tunnel syndrome, right greater than left and chronic right 5-6 radiculopathy.

On February 10, 2009 myelogram is still desired. The patient is doing HEP. Examination remains unchanged.

Progress report dated March 10, 2009 notes Opana is insufficient for pain relief at current dosage. Return to the DD is planned. Myelogram remains pending.

A Designated Doctor Evaluation was provided on March 25, 2009. The patient is reporting persisting neck and right arm pain. Overall the treatment was reasonable, although the medications are questioned. The patient remains off work and states she is unable to do her ADLs. Her job entailed primarily paperwork. Unfortunately she was let go in December of 2008. She continues to report high pain levels. She is 5' 8" and 195 pounds. Sensation was intact right and left, but there was hyposensation primarily in the right median distribution. Motor strength was intact. She has probable right C6 radiculopathy. Additional imaging may be needed if the prior recommended CT scan had not been done. A selective nerve root block or transforaminal ESI would be indicated to assess for radiculopathy. A medial branch block would be indicated to assess for posterior column etiology. Both ESI and facet injection were recommended as a diagnostic tool. The patient reported complaints of neck and bilateral arm, hand and finger pain with swelling into the right hand. She noted a MVA of 1995 that resulted in multiple cervical surgeries including a fusion at C4-5. She also has asthma, high blood pressure, GERD and Cushing Syndrome.

CT myelogram was reviewed on March 27, 2009 and showed a prior anterior cervical fusion C5-6 and a strut graft from C4-7. There appeared to be solid fusion C4-7. Per the provider, there is significant degeneration below the fusion and suggestion of nerve root irritation at left C7, although her pain is mostly on the right. She is referred for right-sided selective nerve root blocks for further assessment of radiculopathy.

On March 27, 2009 CT myelogram was reviewed by the neurosurgeon. The provider recommended right selective nerve root block to assess which nerve is involved and further aid surgical planning.

Procedure report dated May 28, 2009 described cervical foraminal ESI at right C7.

On June 16, 2009 the patient reported a pain level of 6/10.

CESI performed June 16, 2009 reduced right arm pain immediately. One week later the patient noted 80% relief. The left arm pain was not affected.

The patient returned to the neurosurgeon on June 26, 2009. She has had one CESI and is using narcotic medication. She rates her pain as 4-5/10. She reports increased pain since her last visit. She has cervical spondylosis with myelopathy. She has a pseudoarthrosis of her previous ACDF, which could be responsible for her progressive neck pain. Recommendation is for injections and then consider surgery to augment to fusion posteriorly.

Progress report dated July 9, 2009 reports sensory deficit in the right C6 dermatome. Motor strength and reflexes are normal. She had one ESI with pain relief of more than 50% for several days. Opana helps for about 6 hours then she needs something additional. A second ESI was recommended. Refills were given for Skelaxin and Opana ER.

The patient was provided a second CESI on August 13, 2009.

On September 1, 2009 the patient reported a pain level of 5/10 with medications. She states great relief with the CESI and currently about 65% pain relief. She will continue to taper Opana and will consider suboxone. She uses Norco at night. She has now completed both CESI. On September 8, 2009 she reports a pain level of 8/10. A sensory deficit is noted in the bilateral C7 distribution. It was decided not to authorize suboxone but to use Methadone instead due pulmonary issues. She has been off Opana for 6 days and she is in withdrawals but getting better.

Designated Doctor opinions were provided on September 22, 2009. Her fusion appears solid and there does not appear to be a substantial pathology per CT myelogram such as a discal herniation. She reported some benefit from a right-sided CESI which first with her symptoms. She also has significant spasm and guarding about the neck which needs to be addressed. She could benefit from more aggressive manual therapy and stretching; Botox might even be tried for myofascial pain. A medial branch block below the fused levels may be indicated to further delineate her actual pain generator. She is not surgical and could be MMI in 3-4 months. Her medications need reassessment. Per the FCE she can function at a higher level than she demonstrated due pain behaviors. She could return to some type of job. She is scheduled to see a specialist to discuss a surgery. She demonstrated minimal cervical ROM. Reflexes are equal and no motor weakness was found. On sensation testing however there was some slight hypoesthesia of the right index and middle fingers. She would not flex or abduct her right shoulder beyond 90 degrees. Diagnosis is right shoulder and cervical strain and right cervical radiculitis.

The patient returned to the neurosurgeon on September 25, 2009 for reevaluation and consideration of a cervical surgery. She is unchanged with average pain of 5/10. Sensation and reflexes are normal. Motor strength is 5/5 in all major groups. She got one month of excellent relief after her recent CESI, but today her pain has returned to baseline. One option is surgery with posterior augmentation of her fusion from C5 to T1. Her symptoms are otherwise generally livable with the injections, so she should ideally continue with these. She will consider a surgery.

On September 29, 2009 the patient reports a pain level of 8/10. She is having a drug reaction to methadone with SOB and rash and sore tongue. She will start Duragesic. She saw the orthopedic surgeon and is willing to proceed with the recommended cervical surgery. She can do injections and meds in the meantime if she desires.

FCE performed September 29, 2009 showed the patient to be functioning at a Sedentary PDL. The history noted cervical fusion C2-T1 with hardware in 1995 due a MVA and facial injuries requiring placement of an artificial left eye socket. She states she was able to return to work. There is noted a history of aortic deficiency, heart murmur, heart palpitations and hypertension managed with medications. She also has asthma and chronic bronchitis with shortness of breath.

At reevaluation of October 6, 2009 the patient expressed reluctance to proceed with a surgery but will discuss it further with her family. She was told to expect about 75% overall relief with a surgery.

On October 22, 2009 the patient clarified that her "reaction to methadone" was actually from a chair she cleaned at home. Both she and her spouse got the rash from the chair. She got off the Duragesic the day prior and started methadone this AM and is doing okay at 5 mg every 12 hours.

On November 17, 2009 the patient reported increased neck and bilateral arm pain. She will return to the neurosurgeon December 3, 2009 for further treatment planning. Her examination remains unchanged as throughout the entire history of treatment (pain with palpation over the cervical 2-7 spinous processes and bilateral cervical paraspinal muscles; tenderness to palpation with pain radiating to each arm and scapular areas. Sensory deficit noted in the bilateral C7 dermatomal distribution; brisk pulses and symmetric reflexes. Muscular strength is 4/5 bilateral sternocleidomastoid and bilateral trapezius. ROM is limited and compression maneuver is positive.)

The patient fell on December 15, 2009 and reported increased pain. The Lunesta is not sufficient for good sleep; it causes her to jerk and have narcoleptic episodes during the day. She will try trazadone. Refills were given of Methadone, Neurontin and Skelaxin. The patient saw the neurosurgeon the next day and it was decided to continue pain management.

A Surgery Planning Worksheet dated January 4, 2010 indicates consideration for a surgery with fusion at C5-6, C6-7 and C7-T1.

Provider notes of January 14, 2010 indicate the patient had to discontinue methadone due to developing CHF. She is doing well and no withdrawal symptoms were reported. She is ready to restart the cervical ESI series again.

Progress report of February 9, 2010 indicates unchanged examination (cervical pain C2-7 with palpation, sensory deficit in bilateral C7 distribution, brisk reflexes, 4/5 muscle strength in large groups and limited ROM). Medications are refilled.

A Designated Doctor examination was conducted on April 12, 2010. She has reached statutory MMI. She notes some improvement in her head and neck positioning. ROM continues to be very restricted. Right arm pain continues and is confined to the 1st, 2nd and 3rd fingers and there is some left shoulder pain. She uses tramadol, Neurontin, Skelaxin and Trazadone. She

wears a hand brace. She uses hot and cold packs and does HEP. She states injections and surgery have been denied. She underwent right ESI at C7 on May 28, 2009. Additional injections were recommended on June 29, 2009. She had a second ESI with similar temporary response. Her provider deemed her MMI on September 22, 2009 and recommended a medial branch block below the level of fusion. FCE of September 29, 2009 showed her to be at a Sedentary capacity. She smokes one-half pack daily. Motor strength is grossly intact with some diffuse weakness in the right shoulder girdle likely secondary to pain. Sensation is intact in the C5 distribution. There is decreased sensation in the middle fingers and the radial aspect of the pinky finger. Diagnosis includes probable right C6 radiculopathy, plus/minus C7. EMG and NCS verified chronic C6 radiculopathy and CTS, right greater than left. She likely had a stretch induced radiculitis to the C7 and possibly C6 nerve roots. Treatment of her pain complex should include facet joint or medial branch and appropriate treatment for facet-mediated pain. She is not at MMI. Surgical intervention is unlikely at this time. She appears to have a WPI of 15%. She can do Sedentary work per the FCE.

Impairment rating dated April 27, 2010 summarized the treatment history. In regard to CESI, a right C7 CESI was provided on 5/28/09 with temporary help and it was felt surgery should be considered. A second CESI provided similar response of temporary relief. In regard to the assigned WPI of 15%, the reviewer did not find that these met the guideline criteria as the claimant does not meet the criteria for radiculopathy. There was insufficient atrophy to allow radiculopathy and reflexes were not reported by the DD.

Peer review was conducted on May 5, 2010. The entire treatment history was summarized. The 15% impairment rating is again opined to not meet guideline criteria. Medication use was discussed: Ultram is indicated as a narcotic analgesic. Tramadol is mentioned without opinion as to appropriateness. Lyrica is supported. Trazadone is supported. Continued use of Skelaxin is not supported.

On May 11, 2010 the patient was trialed on subutex for one week for increased symptoms. On May 18, 2010 the patient is reported to have problems with subutex including difficulty breathing and global itching and coughing. Due her history of asthma, subutex was discontinued and tramadol given in the interim. On June 1, 2010 she was stable with the suboxone, but was itching. A psychological evaluation for spinal cord stimulation was denied. The request will be sent to the ombudsman. On June 17, 2010 the itching from Suboxone continued. Swelling of the feet was also noted and increased lung secretions. Subutex was stopped "and Nucynta." She will not see her cardiologist or private physician before going out of town to see her children. She is depressed with her situation. She would be a good candidate for trial of SCS.

On July 1, 2010 the provider noted psychology treatment and change of provider were denied. Since stopping Subutex she is using ibuprofen. She will see the Designated Doctor on July 13, 2010 for MMI consideration. She desires implantation of spinal cord stimulator.

The patient underwent a "post DD RME" evaluation on July 13, 2010: She had reached statutory MMI. Impairment was again discussed. The EMG study was suspect. It was determined that she does qualify for a radicular condition (right C5-6 area) based on polyphasics in the right deltoid. This would support the 15% WPI previously assigned. There was also note that she does not have atrophy greater than 2 cm and there were no reflex changes. As such she would not have a confirmatory radiculopathy. Recommendation was for consideration of a repeat electrodiagnostic study to confirm whether or not she does have a radiculopathy. The treatment history was again summarized: The provider is currently trying to get approval for trial of spinal cord stimulation. To date, the psychological evaluation has been denied. Her current medications are Gabapentin, trazadone and Nucynta and these seem to be working, although she states she is unable to work. Her current complaints include pain in her neck and both arms, hand, fingers with swelling into the right hand. She also reported pain in the upper and lower part of her neck. Cervical ROM is limited in all planes, partly due to guarding secondary to pain. She would not flex or abduct her shoulder past 90 degrees. Reflexes are normal. She reported slight hypoesthesia of the right middle finger. Diagnosis is right shoulder and cervical strain and right cervical radiculitis.

On July 29, 2010 the patient reports increasing weakness in the arms, especially the left arm. She is unable to hold a 20 oz. Bottle of water.

Progress report dated August 24, 2010 notes the patient is doing well using Nucynta. She will be seen by her private physician for difficulty swallowing.

On September 21, 2010 a sleep study was recommended. She gets drowsy about 2-3 hours after taking Nucynta. The dose and frequency of this medication were recommended for adjustment.

Reevaluation of October 19, 2010 notes persisting pain radiating down the arms, previously helped by ESI. Another ESI will be ordered. Psychological evaluation denied. Treating doctor change denied. She stopped subutex on 6/19/10 and is using ibuprofen since with less itching and swelling. Getting Nucynta tomorrow and will try that for pain relief. She wants implantation of spinal cord stimulation.

Progress report dated October 26, 2010 notes neck and radiating right arm pain of 7-8/10. Dilaudid was previously tried and caused itching and slowed breathing. She would like to go back to Nucynta. A sleep study was done (through another provider)

on October 14, 2010; the result will be requested. They assessed her dysphagia but did not find anything. She had a triple cardiac screening which was within normal. She is frustrated. TENS and a sleep study have been denied. Her psychology visit for a stimulator trial has also been denied. Spinal cord stimulation is strongly recommended.

Request for Cervical Epidural Steroid Injection - C7 was considered in review on November 10, 2010 with recommendation for non-certification. A peer discussion was conducted with the PA. 118 pages of records were reviewed. The patient is age xx and underwent cervical fusion in 1995. She has been treated for neck and right arm pain since assisting with a in February 2008. X-rays showed possible loosening of one of the anterior screws. MRI showed mild stenosis from facet changes C7-T1 and C2-3, no acute disc herniation and normal EMG except for evidence of carpal tunnel syndrome. CT scan showed prior fusion C5-6 with a strut graft C4-7 and probably solid fusion C4- C7. However, there is significant spondylosis C7-T1 with kyphosis, and possible decreased filling of the left C7 nerve root. Note of February 2010 indicates a pain level of 5/10. Sensory deficit is noted in the bilateral C7 dermatome. Cervical compression is positive. Effectiveness of previous injections is not reported in the notes of February 9, 2010. A third ESI at C7 was denied in review on February 16, 2010. Notes of October 26, 2010 indicate radiating pain into the right arm of 7/10 but does not state date of last injection or patient's response. A graph indicates numerous injections provided this year with 50% relief, but does not indicate specifics. ESIs in 2009 each helped about one month and then pain returned. The PA faxed additional records but they did not sufficiently clarify the patient's response to previous ESI. Office note of 9/1/09 indicates 65% relief with second ESI, but the date if the ESI is not stated [8/13/10]. Office note 7/9/10 indicates 50% relief from the first ESI, but the date of the first ESI was not stated [6/16/10]. Office note 10/22/09 indicates change in medication from Duragesic patch to methadone due to rash which was determined to be from a chair and not the medications. Rationale for denial states the outcome of previous ESIs did not meet the criteria needed to support the request.

The patient was most recently reevaluated on November 16, 2010. The patient reports a pain level of 4-5/10 with medications. She smokes cigarettes. She has depression. Diagnosis includes bulging cervical disc and post-laminectomy syndrome cervical region. Medications are listed as Neurontin, Tramadol, Nexium, Lasix, Apsirin, Effexor and Extretest. She is 5' 8" and 190 pounds. Sensation deficit is noted in the bilateral C7 dermatome. Muscular strength is grossly 4/5 in the sternocleidomastoid, prevertebral extensors and bilateral trapezius. Her pain has improved slightly with the increased Nucynta. She is also using Skelaxin, Neurontin and Ultram. Additional information regarding prior ESI is provided: She has had two previous CESI. The first was on 5/28/09. At office visit of 7/9/09 6 weeks later, she reported 50% relief. There was no documentation regarding improved functionality, however, the patient states at today's visit, she did experience increased functionality with injections. There were no changes in medications during that time period. In the office note of 9/1/10 or 3 weeks following a CESI the patient states relief of 65%. She was taken off Opana at that time, but then later started on a different medication. At today's visit she reports she had relief for 2 months with her last injection referring to the injection of 8/13/09.

Request for reconsideration Cervical Epidural Steroid Injection - C7 was considered in review on December 1, 2010 with recommendation for non-certification. 35 pages of records were reviewed. A peer discussion was attempted but not realized. A sensory deficit was noted in the bilateral C7 distribution. Strength was diminished but symmetrical throughout. The patient had two previous CESI. Following the initial injection of 5/28/09 the patient reported 50% reduction in pain 6 weeks later. A second CESI was provided on 8/13/09 and the office note of 9/1/10, three weeks later, state she had 65% relief. On the current visit, the patient reported two months of relief with the last injection. Rationale for denial states the documentation submitted for review is not inclusive of electrodiagnostic studies or imaging studies indicating radiculopathy.

Carrier submission dated December 27, 2010 notes the requested CESI was initially non-certified two times. The recent reviewer noted the office note of 10/26/10 does not indicate any neurologic findings on exam to support C7 radiculopathy. EMG (2/6/09) is normal except for right CTS and chronic C5-6 radiculopathy. The appeal reviewer noted the documentation is not inclusive of electrodiagnostic studies or imaging studies indicating radiculopathy.

Request was made for an IRO.

Analysis and Explanation of the DECISION INCLUDE clinical basis. Findings and Conclusions Used to Support the Decision.

ODG - Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.

The patient is fused C4-C6 (effectively to C7). C7-T1 disc is thin and there is kyphosis and possible loose anterior screws per radiographs of January 2009. The C4-6 fusion is non-compensable as it resulted from an auto accident in 1995. CT scan of November 2008 showed a spur directed inferiorly with near complete loss of disc height at C7-T1 and is associated with kyphosis at C7 (moderate) as well as wedging of C7 (65% loss of height). While this is not a typical pseudoarthrosis, the amount of disc degenerative change, kyphosis and wedging is thought likely to be a pain generator at C7-T1.

The patient has had ongoing difficulty with mechanical restriction and guarding in the neck resulting in awkward neck postures, a

condition noted to be slowly improving. The pain generator has never been fully clarified and radiculopathy has also been equivocal. The patient is reportedly not surgical. In March 2009 the DD recommended both ESI and facet injection as diagnostic tools. Several ESI have been provided with (again) equivocal response for radiculopathy. There was brief therapeutic benefit noted. On September 22, 2009 the DD again recommended a diagnostic facet injection (A medial branch block below the fused levels may be indicated to further delineate her actual pain generator.) The most current DD opinions of April 12, 2010 again recommend diagnostic facet injections, but these have not been provided.

It does not appear that additional ESI are indicated for this patient. The Impairment evaluator determined some radiculopathy appears to be present based on (right C5-6 area) based on EMG findings of polyphasic in the right deltoid, however this does not correlate with a clinical C7 radiculopathy and the current request for epidural. The impairment evaluator also noted that she does not have atrophy greater than 2 cm and there were no reflex changes and, as such, she would not have a confirmatory radiculopathy. The presence of radiculopathy remains equivocal, but has been allowed for rating purposes.

Aside from the lack of clarity in duration of response to the several ESI provided, these injections, as noted, have not been recommended on a therapeutic basis. Prior injections have not resulted in ongoing functional benefit. It has been 16 months since the most recent ESI and the patient appears to be stable on her current medications of gabapentin, Trazadone and Nucynta (7/13/10: seem to be working). Based on all these facts, repeat ESI does not appear to be an appropriate treatment plan at this time.

Therefore, my recommendation is to agree with the previous non-certification for Cervical Epidural Steroid Injection - C7, 62310, 77003, 991441

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
- AHCP- 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

The Official Disability Guidelines 12-15-2010 Pain chapter: 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. [NOTE: This treatment for Low back & Neck pain is primarily covered in those respective chapters.] Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. See the Low Back Chapter for more information and references. 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

- Criteria for the use of Epidural steroid injections:

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 be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)
- 8) 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.
- 9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block