

## Notice of Independent Review Decision

**DATE OF REVIEW:** FEBRUARY 28, 2011

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Outpatient cervical ESI C5/6 w/fluro 64479, 77003

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

This physician is a Board Certified Neurosurgeon with 46 years of experience.

### **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.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

On xx/xx/xx, M.D. performed a Designated Doctors Evaluation. He determined that the extent of the claimant's compensable injury is post traumatic lumbar syndrome and cervical sprain/strain.

On January 21, 2010, the claimant was evaluated by M.D. She continues to have chronic posterior cervical and interscapular pain with bilateral radicular shoulder and arm pain with feeling of numbness, dysethesias and weakness in the arms. She has weakness of the triceps and biceps with decreased reflexes and decreased sensation in the C6 and C7 dermatomes.

On March 29, 2010, the claimant was re-evaluated by, M.D. She has increasing numbness in all four extremities. She has a Lhermitte phenomenon with flexion and extension of the neck. She is incapacitated by this problem. Surgical intervention was denied.

On May 24, 2010, an MRI of the cervical spine was performed. Impression: Multilevel cervical spondylitic changes with disc bulges at C3 through C7 as interpreted by M.D.

There is a letter dated June 14, 2010 from M.D. stating that the claimant has severe problems at C5-6 and C6-7 with disk osteophyte and cord compression with canal stenosis. Any range of motion of the neck causes Lhermitte phenomenon. She has numbness and weakness in all four extremities. She has a wide based gait, Babinski response and ankle clonus. She wants to proceed with surgery and understands the risks.

On July 21, 2010, the claimant underwent surgical intervention of the cervical spine as performed by M.D. Procedures: 1. Anterior discectomy at C5-6 and C6-7 with bilateral C7 root decompression and excision of herniated disk and decompression of central canal and spinal cord. 2. Interbody fusion C5-6 and C6-7. 3. Placement of machine cage allograft interbody, C5-6 and C6-7. 4. Morselized autograft and allograft, interbody C5-6 and C6-7. 5. Application of anterior plate at C5, C6 and C7.

On August 12, 2010, x-rays of the cervical spine were performed. Impression: 1. Status post discectomy and placement of prosthetic disk material from C5 through C7. 2. Otherwise normal single lateral view of the cervical spine as interpreted by M.D.

On August 12, 2010, the claimant was re-evaluated by M.D. She has improved significantly since her surgery. X-rays show good position and alignment. She no longer has any radiating arm pain and increased sensation and strength in all four extremities.

On October 28, 2010, x-rays of the cervical spine were performed. Impression: Post-op cervical spine without acute abnormality as interpreted by M.D.

On October 28, 2010, the claimant was re-evaluated by M.D. She has very little pain in the neck and no radiating shoulder or arm pain. She has good flexibility

of her neck. She takes Hydrocodone, Flexeril and Motrin. She did have L5-S1 surgery 5 years ago and is secondary to her injury.

On December 20, 2010, the claimant was re-evaluated by M.D. Because of posterior cervical and interscapular pain with discomfort in both arms, a cervical Depo-Medrol injection was recommended.

On December 8, 2010, M.D., an anesthesiology physician, performed a utilization review on the claimant. Rational for Denial: Based on the medical records dates 10/28/10, the patient does not have radiating shoulder or arm pain. This request for a cervical Epidural Steroid Injection cannot be substantiated because no official and serial physical therapy notes were submitted to document failure of conservative management. Therefore, it is not certified.

On January 5, 2011, M.D., a neurosurgeon, performed a utilization review on the claimant Rational for Denial: Due to lack of documentation of radiating shoulder or arm pain, imaging reports or electrodiagnostic studies documenting radiculopathy and failure of conservative treatments: therefore, it is not certified.

#### **PATIENT CLINICAL HISTORY:**

On xx/xx/xx, the claimant sustained an injury to the lumbar and cervical spine when she was working . As she went down she grabbed onto the edge of the sink, her hands were wet and she could not hold on and she fell to her right side. There was a cart sitting just to the right of her and as she fell she struck her head and face on the cart with considerable force.

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

The previous decisions are upheld. Based on the medical records provided for review there is no of documentation of radiating upper extremity pain, no EMG/NCV studies, and no documentation of radiculopathy on clinical examination. Therefore, based on the ODG the outpatient cervical ESI C5/6 w/fluro is not certified.

#### **ODG**

##### **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), and imaging studies have suggestive cause for symptoms but 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)