

Notice of Independent Review Decision

DATE OF REVIEW: May 29, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical epidural steroid injection at C5-C6 and C6-C7 levels

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

Board Certified Orthopedic Surgeon

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Medical documentation does not support the medical necessity of the health care services in dispute.

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

TDI

- Utilization reviews (04/17/12, 05/08/12)

xxxxx

- Office visits (04/23/10 – 05/02/12)
- Diagnostics (05/25/10 – 02/27/12)
- Reviews (12/16/10 – 09/15/11)

- Diagnostics (07/01/10 - 02/06/12)
- Office visits (07/01/10 - 04/25/12)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was driving a company vehicle when apparently he was rear-ended by a second vehicle on xx/xx/xx. As a result of the collision, the patient sustained injuries to his neck, low back and thoracic spine regions.

2010: On xxxxx, M.D., evaluated the patient for headaches, pain radiating into the upper extremities, pain in the cervical, thoracic and lumbosacral spine and loss of range of motion (ROM). Dr. noted that the patient had been previously evaluated at the Medical Center. He had undergone x-rays and computerized tomography (CT) scans and was started on Motrin and hydrocodone. Examination of the spine showed mild-to-moderate tenderness, slight tenseness of the paravertebral muscles and painful and slightly decreased ROM in all directions. Dr. diagnosed cervical, thoracic and lumbosacral spine sprain; prescribed hydrocodone, Mobic and Zanaflex; recommended physical therapy (PT) and ordered x-rays of the cervical, thoracic and lumbosacral spine.

Magnetic resonance imaging (MRI) of the thoracic spine showed: (1) Possible old mild compression fracture at T11. (2) Mild anterior wedging deformity. (3) T4 indentation superior endplate possibly and old traumatic Schmorl's nodes with minimal spondylosis at T3. (4) Mild increased kyphotic curve of the thoracic spine, etiology unclear, might be developmental.

MRI of the lumbar spine showed: (1) At L3-L4, a 2-mm annular symmetrical disc bulge with mild neural foraminal narrowing. (2) At L4-L5, 2 to 3 mm annular symmetrical disc bulge, high-grade right neural foraminal narrowing with possible extrinsic compression against the exiting right L5 nerve root sleeve. There was moderate narrowing of the left neural foramen. (3) At L5-S1, there was a 2-mm focal central disc protrusion with no neural foraminal narrowing.

M.D., an orthopedic surgeon, evaluated the patient for cervical pain and pain in the posterior mid area radiating to the bilateral upper extremities. The patient also had low back pain with some discomfort with side-to-side movement, soreness and stiffness and pain radiating down into his right lower extremity. The patient also experienced numbness, tingling and weakness in his entire right leg. The patient was uncomfortable sitting in his chair and had difficulty getting up out of the chair and on to the examination table. His patellar and Achilles reflexes were blunted bilaterally and barely elicitable. Motor strength was weak on the right as compared to the left and he had decreased sensation in his right lateral leg. He had severe tenderness along the lower lumbar region and decreased ROM in all directions secondary to pain. He had a mildly positive straight leg raise (SLR) on the right. Examination of the cervical spine showed severe tenderness along the posterior cervical region with decreased ROM in all directions secondary to pain. He had a positive axial compression test. Dr. obtained x-rays of the cervical and lumbar spine which were unremarkable. He reviewed MRI findings of the thoracic and lumbar spine and diagnosed L4-L5 protrusion with radiculitis, thoracic strain and possible herniated nucleus pulposus (HNP) of the cervical spine. Dr. noted that the patient had exhausted

PT as well as medications without relief. He recommended a lumbar epidural steroid injection (ESI) in conjunction with post-injection PT and continuing anti-inflammatories as prescribed by Dr..

On September 2, 2010, electromyography/nerve conduction velocity (EMG/NCV) studies of the lower extremities showed chronic right L5 root irritation consistent with radiculopathy and possible bilateral sensory and motor polyneuropathy.

MRI of the cervical spine showed: (1) Relative straightening of the mid cervical lordosis with no spondylolisthesis. There was moderate disc space narrowing at the C5-C6 level. (2) At C4-C5, a posterior 1 to 2 mm disc protrusion pressing on the thecal sac with no neural foraminal narrowing. (3) At C5-C6, a posterior 2-mm disc protrusion/herniation pressing on the thecal sac with no neural foraminal narrowing. (4) At C6-C7, a posterior 2 to 3 mm disc protrusion/herniation pressing on the thecal sac with no neural foraminal narrowing. Moderate facet hypertrophy of the apophyseal joints was identified bilaterally.

Dr. reviewed the MRI findings and diagnosed protrusion of L4-L5 with radiculitis, thoracic strain and disc protrusion and herniation of C5-C6 on the right. He recommended proceeding with cervical and lumbar ESI and post injection PT. He also recommended obtaining EMG that was ordered by Dr. .

On November 9, 2010, Dr. performed an ESI at the L5-S1 level with 80% improvement and recommended repeat lumbar ESI.

On November 15, 2010, an independent review organization (IRO) upheld the denial for cervical ESI injection at C5-C6.

On December 16, 2010, M.D., performed a designated doctor evaluation (DDE) and opined that the patient was not at maximum medical improvement (MMI). Dr. opined that the patient should obtain the post injection PT and an additional ESI in the lumbar area to provide some pain relief. The patient could return to work with restrictions.

2011: Per the utilization review dated January 25, 2011, the request for bilateral upper extremity EMG/NCV was denied.

Dr. noted the patient had disc protrusion at C5-C6 and the radiating and burning pain to his scapula likely related to that. He ordered an upper extremity EMG. The patient had been complaining of numbness as well as weakness. Dr. recommended follow-up after upper extremity EMG and renewing the medication by his treating doctor.

On March 8, 2011, an IRO upheld the denial for ESI at the L4-L5 level. On March 15, 2011, the request for EMG/NCV of the upper extremity was denied.

On March 29, 2011, M.D., performed a DDE. He obtained a functional capacity evaluation (FCE) that showed objective evidence that the patient was able to perform at medium physical capacity level only. The electrodiagnostic studies of the lower extremities showed right lumbosacral radiculopathy in the L5-S2 distribution, acute and chronic findings, and suggestion of a left lumbosacral radiculopathy in the L4-S2 distribution. Dr. opined the patient had not reached

MMI and would benefit from invasive pain procedure for both neck and low back combined with strengthening exercise.

On September 15, 2011, Dr. performed a DDE and opined that the patient had reached statutory MMI with 10% whole person impairment (WPI) rating.

In December, Dr. evaluated the patient for persistent cervical spine pain radiating down to his scapula and lumbar pain with lower extremity weakness and numbness. He reviewed the previous EMG and MRI findings and recommended a laminectomy and foraminotomy at L4-L5 bilaterally without discectomy.

2012: In January, Dr. noted that the surgery was approved. However, the approval window coincided with the holidays and the patient was unable to schedule his surgery. He complained of back pain radiating into both lower extremities. Dr. recommended surgery.

On February 6, 2012, EMG/NCV of the bilateral upper extremities was most consistent with active radiculopathy processes involving the bilateral C6 and C7 segmental regions with superimposed sensorimotor axonal polyneuropathy in the upper limbs.

On February 21, 2012, Dr. performed bilateral L4-L5 laminectomy and foraminotomy. Postoperatively, Dr. recommended starting aggressive postoperative PT for lumbar spine, obtaining EMG of the upper extremities prior to the next visit and continuing medications as prescribed.

On follow-up, Dr. noted the patient was doing well with regard to his lumbar spine. He recommended aerobic exercises to improve his conditioning and core motor strength. For cervical spine, he recommended cervical epidural injections to help with the patient's radiculopathy.

Per utilization review dated April 17, 2012, the request for ESI at C5-C6 and C6-C7 was denied based on the following rationale: *"The EMG/NCV studies, although identify active radiculopathy process involving bilateral C6 and bilateral C7 segment regions, there is also superimposed sensory motor axonal polyneuropathy in the upper limbs. The MRI evaluation of the cervical spine dated September 21, 2010, documents at C5-C6 posterior 2-mm disc protrusion/herniation pressing on the thecal sac with no neural foraminal narrowing and at C6-C7 posterior 2-3 mm disc protrusion pressing on the thecal sac with no neural foraminal narrowing with moderate facet hypertrophy of the apophyseal joints identified bilaterally. There is straightening of the cervical lordosis consistent with spasms and disc pathology identified at C4-C5, C5-C6 and C6-C7. The patient had no documentation of failed lower levels of care targeting the cervical spine including physical therapy, specified use of medication or an exercise program. Therefore, without clear objectified pathology by diagnostic examination studies and without failure of lower levels of care targeting the cervical spine, the request for epidural steroid injection therapy at C5-C6 and C6-C7 is not medically supported."*

On April 25, 2012, Dr. opined that the patient was first seen on July 1, 2010, and as time progressed his symptoms increased in nature. He had exhausted PT and oral anti-inflammatories with temporary relief. On May 2, 2012, Dr. refilled

medications and appealed for cervical ESI as the diagnostic studies matched with the physical examination findings.

Per the reconsideration review dated May 8, 2012, the appeal for cervical ESI at C5-C6 and C6-C7 levels were denied based on the following rationale: *“It does appear that the patient has chronic neck pain and may have some cervical radiculopathy. The request however is for two level C5-C6 and C6-C7 ESI. The Official Disability Guidelines state that no more than one interlaminar level should be performed at one session, thus it cannot be approved.”*

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

This is a male with chronic neck pain dating back to xx/xx/xx. The claimant had findings of radiculopathy on serial examinations that has been refractory to physical therapy, medications and off work. Dr. has recommended C5-6 and C6-7 cervical epidural steroid injections. That said, the Official Disability Guidelines state no more than one interlaminar level should be injected at one session. The request is for two injections. Based on evidence based guidelines, the request for the C5-6 and C6-7 cervical epidural steroid injection are not recommended as medically necessary.

Official Disability Guidelines Treatment in Worker’s Comp, 17th edition, 2012 Updates, chapter neck and upper back

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.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

IF YOU ARE NOT UTILIZING THE ODG GUIDELINES YOU MUST STATE WHY, PER TEXAS DEPARTMENT OF INSURANCE.

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES