

# AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

**[Date notice sent to all parties]:** June 29, 2012

**IRO CASE #:**

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

ESI Injection to the Cervical 62310 77003 @ C4-5 C5-6 C6-7

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

This physician is Board Certified Physical Medicine and Rehabilitation with over 16 years of experience.

**REVIEW OUTCOME:**

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

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

03-19-12: MRI C-Spine W/O Contrast at Imaging dictated by MD

04-10-12: Initial Pain Evaluation at Anesthesia, LLP dictated by DO

04-16-12: Progress Note dictated by RN, FNP

04-20-12: UR performed by MD

04-30-12: Progress Note dictated by RN, FNP

05-03-12: Follow-up Note at Anesthesia dictated by DO

05-11-12: UR Referral for Cervical ESI requested by DO

05-24-12: Neurologic Consultation at Neurological Center dictated by MD

06-05-12: UR performed by MD

06-12-12: Follow-up Note at Anesthesia dictated by DO

06-18-12: Upper Extremity NCV and EMG Study Report at Neurological Center dictated by MD

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who was driving when he was struck by a lady going through a red light on xx/xx/xx. He swerved and ended up hitting a metal pole and jammed his head inside the truck, perhaps loss of consciousness for a few

seconds, maybe one minute. He immediately started having spasms and neck pain associated with numbness, weakness, and tingling down both arms.

03-19-12: MRI C-Spine W/O Contrast dictated by MD. Impression: 1. 3 mm central disk protrusion at C5-C6 compresses the cord surface and narrows the canal. A fissure in the annulus if present. 2. 2.5 mm central disk protrusion at C4-C5 compresses the cord surface and narrows the canal. 3. Loss of disk height with 2 mm broad-based disk bulge or protrusion at C6-C7. Mild flattening of the cord surface and canal stenosis is present. 4. 1.3 mm Internalizing disk bulge to the left midline at C7-T1. A fissure in the annulus is present. 5. Bilateral foraminal stenosis at C5-C6 and C6-C7 present.

04-10-12: Initial Pain Evaluation dictated by DO. The claimant presented with chief complaint of chronic, persistent neck, right shoulder, arm and hand pain associated with numbness, weakness, and tingling down both arms following a work-related injury. Aggravating factors per the claimant included sitting, coughing, sneezing, and lifting. Physical Examination: Claimant was in moderate distress secondary to chief complaint. Neck was supple with decreased left and right rotation at 40 and 60 degrees, respectively. Claimant was able to bring his chin within one inch of chest with reproduction of neck pain. Claimant had moderate mid cervical interspinous tenderness with moderate trigger point tenderness in his interscapular and rhomboid regions extending into his lumbar spine. Dr. noted mild decreased pinprick sensation in the right arm at C5-6 distribution and decreased grip strength. Diagnosis: 1. Chronic neck pain syndrome associated with multiple levels of disk protrusion following work-related injury. 2. Cervicogenic headache. 3. Myofascial pain syndrome of the cervical, mid thoracic, and lumbar regions associated with #1. Dr. recommended ESI to decrease recovery period, further medication management to decrease symptoms of sleep disturbance, improve pain tolerance, and enhance mood control. Prescribed two prescriptions amitriptyline and hydrocodone. Will treat cervical area pain after pain control achieved and consider lumbar spine treatment.

04-16-12: Progress note dictated by RN, FNP. Objective: Affected side: Cervical Bilateral, Tenderness to Palpations: Bony areas: facet joints C2-6, Soft tissue areas: trapezius muscle. Neurological Examination: C5 Relax (Biceps): 2+, Muscle (Deltoid and biceps): 5/5, Sensation (Bilateral arm): Intact; C6 Relax (Brachioradialis): 1+, Muscle (Wrist extension and biceps): 4/5, Sensation (Bilateral forearm): Diminished; C7 Relax (Biceps): 2+, Muscle (Wrist flexors, finger extension, triceps): 5/5, Sensation (Middle finger): Intact; C8 Muscle (Finger extension, hand intrinsic): 5/5, Sensation (Medial forearm): Intact; T1 Muscle (Hand Intrinsic): 4/5, Sensation (Medial arm): Intact. Assessment: Other Problem: Cervical Disc Displacement: 722.0. Plan: Continue with Our Patient Rehab and follow up with Dr. for cervical ESI. Patient Education: Advised to conform activities that do not exacerbate pain, to use ice massage (ice rubbed over affected for 15-20 minutes three or more times daily), warm compresses over affected areas, to perform range of motion exercises, including flexion, extension,

lateral rotation and bending, muscle strengthening exercises, including flexion, extension, lateral rotation and bending against resistance.

04-20-12: UR performed by MD. Reason for denial: As per medical report on 4/10/12, the patient complained of chronic and persistent pain in the neck and right shoulder, arm and hand. The pain was associated with numbness, weakness and tingling over the arms. Physical examination of the neck revealed decreased left and right rotation with moderate mid cervical interspinous tenderness. There was also trigger point tenderness in the interscapular and rhomboid regions extending to the lumbar spine. He had mild decreased pinprick sensation in the right arm at the C5-C6 distribution and with decreased grip strength. This request is for cervical ESI at C4-C5, C5-C6 and C6-C7. The guidelines recommend ESI be administered at not more than 2 levels. The records indicated that the patient underwent four weeks of conservative care with no decrease in his symptoms. However, there was no comprehensive assessment of the treatment completed to date to include exercises, physical methods and pharmacotherapy. Moreover, a summary of the functional response, changes in the patient's condition, problems encountered, and goals achieved during the previous PT visits were not provided. There was also no documentation of patient's education and training on a home exercise program to aid in the clinical progression and achievement of functional goals. There was likewise no formal plan of the concurrent use of PT and HEP in conjunction with ESI. Lastly, the referenced guidelines do not recommend injection of more than two nerve root levels using transforaminal blocks. Hence, the medical necessity of the requested services is not established at this time. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request for epidural steroid injection to the cervical is not certified.

04-30-12: Progress note dictated by RN, FNP. Assessment: Other Problem: Cervical Disc Displacement : 722.0. Diagnosis: Unspecified Neuralgia Neuritis/Radiculitis : 729.2. Plan: Continue with out patient rehab. Follow up with Dr. for pain management. Referral for Neurological evaluation. Patient Education: Advised to conform activities that do not exacerbate pain, to use ice massage (ice rubbed over affected for 15-20 minutes three or more times daily), warm compresses over affected areas, to perform range of motion exercises, including flexion, extension, lateral rotation and bending, muscle strengthening exercises, including flexion, extension, lateral rotation and bending against resistance.

05-03-12: Follow-up Note dictated by MD. Dr. stated, "It is very unfortunate this legitimately injured gentlemen with clear signs and symptoms consistent with cervical disk protrusions at three levels with right cervical radiculopathy having failed previous conservative medical treatment options has been denied our request for cervical epidural blockade". Dr. noted that the claimant was unsuccessful at pain management and the medications that were given are not strong enough and he is still experiencing pain escalating now up to 7-8/10. The

requested ESI procedure is performed under a single needle placement at C6-C7 interspace, specifically depositing local anesthetic and corticosteroid at three levels, which is not contraindicated with the ODG guidelines.

05-24-12: Neurologic Consultation dictated by MD. Claimant presented with chief complaint of neck and arm pain. Problem Oriented Neuromuscular Examination: Upon direct examination, his strength is 5/5 throughout, except for the right biceps and brachioradialis, 4+/5, subtle weakness though. Muscle strength reflexes are as follows: biceps, triceps and brachioradialis on the left 1+ and on the right biceps and brachioradialis traceable, triceps 1+, both knee jerks 1+ and both ankle jerks 1+, with flexor plantar responses. Sensory examination reveals some hypoesthesia along the posterior cutaneous sensory distribution of his right arm (biceps) to pinprick and light touch, very subtle though. Spine examination reveals tenderness on palpation in the posterior spinous processes, mid cervical region associated with increased tone of paravertebral muscles and some limitations in the range of motion, mostly to the right. Impression: Post-traumatic cervical radicular syndrome. Recommendations: 1. Continue current conservative care with Dr. consisting of ergonomics and cervical spine physical therapy measures. 2. Continue pain management with Dr.. 3. We will obtain his cervical spine MRI results for clinical and physiological correlation. 4. We will proceed with electrical studies of the upper extremities to understand the pathophysiological mechanisms of his symptoms generators. I suspect nerve root compromise at this point. 5. Medications were refilled. 6. Work status as per Dr.. 7. I will see him back with the test results and provide further recommendations for his management as I deem necessary.

06-05-12: UR performed by MD. Reason for denial: The progress report dated 4/10/12 states the patient has pain in the neck and right shoulder, arm and hand. There is associated with numbness, weakness and tingling over the arms. Physical examination of the neck revealed decreased left and right rotation with moderate mid cervical interspinous tenderness. Sensation to pinprick is mildly decreased at the right C5-C6 dermatomal distribution. Right grip strength is decreased. This is an appeal for cervical epidural steroid injection. This request was previously non-certified because the previous request was for injections at more than two spinal levels. There was also no comprehensive assessment of the treatment completed to date to include exercises, physical methods and pharmacotherapy. There was also no documentation of a formal plan of the concurrent use of PT and HEP in conjunction with ESI. The office note dated 5/3/12 clarified that this injection will be performed at the C6-C7 level. However, there was still no objective documentation of failure of response to recommended conservative treatment such as rehabilitation through physical therapy progress reports. There is still no objective documentation that the patient would pursue a formal plan of active rehabilitation such as PT or compliance with a home exercise program in conjunction with the request. For the above reasons, the medical necessity of this request cannot be established at this time. Based on the clinical information submitted for this review and using the evidence-based, peer-

reviewed guidelines referenced above, this request for epidural steroid injection to the cervical C6-C7 is not certified.

06-18-12: Upper Extremity NCV and EMG Study Report dictated by MD.  
 Impression: 1. Active and chronic (Degeneration/Reinnervation) Right C6 Radiculopathy. 2. Incidental Electrophysiologic abnormalities consisting of a right carpal tunnel median entrapment mononeuropathy (CTS) and right ulnar neuropathy at the elbow segment (predominantly axonal type). Clinical, imaging and electrophysiologic correlation is suggested.

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

Denial of Cervical ESI is upheld/agreed upon. Per ODG Neck Chapter – submitted clinical information does not demonstrate response to conservative care: exercise, physical therapy, medications. Therefore, the request for ESI Injection to the Cervical 62310 77003 @ C4-5 C5-6 C6-7 is denied.

Per ODG:

<p>Epidural steroid injections (ESIs), therapeutic</p>	<p><b>Criteria for the use of Epidural steroid injections:</b>  <i>Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.</i></p> <p>(1) Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.</p> <p>(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).</p> <p>(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.</p> <p>(4) <i>Diagnostic Phase:</i> At the time of initial use of an ESI (formally referred to as the “diagnostic phase” as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (&lt; 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.</p> <p>(5) No more than two nerve root levels should be injected using transforaminal blocks.</p> <p>(6) No more than one interlaminar level should be injected at one session.</p> <p>(7) <i>Therapeutic phase:</i> If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (<a href="#">CMS, 2004</a>) (<a href="#">Boswell, 2007</a>)</p> <p>(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.</p> <p>(9) Current research does not support a routine use of a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI</p>
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	<p>injections for the initial phase and rarely more than 2 for therapeutic treatment.</p> <p>(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.</p> <p>(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)</p>
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**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)