AccuReview

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: March 11, 2012
IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
One cervical epidural injection under fluoroscopy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board Certified in Anesthesiology and Pain Management with over 40 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:
11-18-11: Initial Consultation at Pain Institute with, MD
12-06-11: Follow-up Examination at Pain Institute with, MD
12-21-11: MRI of Cervical Spine interpreted by, MD
01-17-12: Follow-up Examination at Pain Institute with, MD
01-26-12: UR performed by, MD
01-31-12: Follow-up Examination at Pain Institute with, MD
02-17-12: UR performed by, DO
02-28-12: Follow-up Examination at Pain Institute with, MD

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who was injured on xx/xx/xx when he went to put the leveling on the lathe and the machine moved and hit him on the head. He was initially seen in the emergency clinic and then went under the care of Dr.. It was reported he had only care from Dr., no treatment. He was referred to Dr. for further pain management.

11-18-11: Initial Consultation at Pain Institute with, MD for complaints of pain to the left side of his face. The claimant reported complaints of sharp pain located to the left side of his face with radiation down to the back of the neck and down the left arm.

He admitted to numbness and tingling to the left side of his face, neck and arm but denied any burning. Current medications were listed as Labetalol, Venlafaxine, Topiramate, Benazepril, Amlopidine, Omeprazole, Zomig, Simvastatin, Traxodone, Tramadol, and Aspirin. On physical examination there was positive and very limited range of motion located to the cervical spine during flexion, extension, lateral rotation and lateral bend. Upper and lower extremity muscle strength was 5/5 on the right. There was some giveaway strength secondary to pain to the left upper extremity. Deep tendon reflexes were: Biceps 1+, Triceps 2+ on the right and absent on the left, Brachial radialis 1+. There were specific areas of active and reproducible trigger pint tenderness noted to the levator, trapezius, rhomboids, splenis capitis, splenis cervicis, left supratrochlear and left supraorbital. There was numbness and tingling to the forehead on the left. There was also a decreased sensation to the left upper extremity versus the right with light touch. There was also atrophy to the left triceps muscle. Impression: 1. Cervical pain with right sided radiculopathy. 2. History of bulging discs and herniated discs at C3-C4, C4-C5, and C5-C6. 3. Myofascial pain syndrome to the trapezius, levator scapulae muscles, rhomboids, splenis capitis, and splenis cervicis. 4. Supratrochlear and supraorbital nerve neuralgia. 5. Acute exacerbation of pain. Plan: Request MRI of the cervical spine and EMG of the upper extremities.

12-06-11: Follow-up Examination at Pain Institute with, MD. On physical examination there was some decreased sensation to light touch to the upper extremities to the left all the way to the hand. His hand grip was also diminished bilaterally. His range of motion of the cervical spine was limited. He was very sensitive to touch to the left temporal frontal region. Assessment: 1. Patient with a history of headaches secondary to an injury. 2. History of cervical pain with radiculitis. Plan: MRI of the cervical spine and EMG of the upper extremities.

12-21-11: MRI of Cervical Spine interpreted by MD. Impression: Changes of cervical spondylosis at the C3-C4 through the C6-C7 levels as described above. (C3-4: There is slight posterior osteophyte formation on the left creating a small left-sided anterior extradural defect. No cord impingement high-grade central stenosis identified. There appears to be moderately prominent bony neuroforaminal narrowing on the left. C4-C5: There is moderate posterolateral osteophyte formation on the right. No central stenosis is identified. Moderately prominent right-sided neuroforaminal narrowing. C5-C6: There is moderate interspace narrowing with slight posterolateral osteophyte formation on the right and left sides. No central stenosis is identified. There appears be slight bony neural foraminal narrowing bilaterally. C6-C7: There is slight posterior osteophyte formation on the left without central stenosis identified. There is moderate bony neural foraminal narrowing on the right and slight bony neural foraminal narrowing on the left.)

01-17-12: Follow-up Examination at Pain Institute with, MD who noted he was having some increase pain. On physical examination he had good hand grip. His reflexes were 1+ to the upper extremities. He had tenderness to the cervical paraspinal muscles including the splenis capitis, splenis cervicis, trapezius, and levator scapulae muscles. He had pain with range of motion to the cervical spine at baseline. He had numbness and tingling from the neck down to the left hand. Assessment: 1. Patient with a history of cervical pain and radiculopathy with an acute exacerbation of his symptoms and evidence of pathology of the cervical spine that causes this pain. Plan:

Recommended he undergo a series of 2 cervical interspinal injections with trigger point injections to the paraspinal muscles under fluoroscopic imaging two week apart in effort to decrease his pain. He was placed on Tramadol, Celebrex 200 mg, and Skelaxin 800 mg. Dr. did perform a trigger point injection with Toradol 60 mg intramuscularly during that office visit.

01-26-12: UR performed by, MD. Reason for Denial: There is inadequate evidence of radiculopathy. Subjective complaints are not documented to be in a dermatomal distribution and there are no consistent clinical findings supportive of radiculopathy. Prior EMG is reportedly negative. MRI did show some foraminal narrowing but there is no correlation with the clinical findings. The request is not justified with the information available.

01-31-12: Follow-up Examination at Pain Institute with, MD. On physical examination he had good hand grip. His reflexes were 1+ to the upper extremities. He had tenderness to the cervical paraspinal muscles including the splenis capitis, splenis cervicis, trapezius, and levator scapulae muscles. His range of motion of the cervical spine was limited secondary to pain. He admitted to numbness and tingling from the neck down to his hands. Dr. did notate that the exam indicated tingling in the left C6-C7 region. Dr. continued to recommend the cervical epidural injections.

02-17-12: UR performed by DO. Reason for Denial: MRI showed bulges and EMG was normal. The patient had 2 RMEs that stated no further tx was necessary. He has an injury that is almost 20 years old. He reportedly has ESIs in the past with relief per Dr. but the RME does not mention them. Based on the patient's age of injury, 2 RMEs, and lack of documentation of past response along with questionable findings, the ESI is denied.

02-28-12: Follow-up Examination at Pain Institute with, MD who noted the claimant continued to have pain and discomfort to the neck and numbness to the base of the skull on the left side as well as numbness to the left hand including the last 3 digits. On physical examination he was in mild to moderate amount of pain. He had active and reproducible trigger point tenderness noted to the splenis capitis, trapezius, and levator scapulae muscle on the left. There was some tenderness and tingling to the tinels with pressure on the left greater occipital nerve with numbness noted to the greater occipital nerve distribution. As far as the left upper extremity, there was some weakness to hand grip. There was some numbness down the left lower extremity in the C7-C8 distribution with slight involvement of C6. Assessment: 1. Patient with a history of cervical pain and radiculitis to the C7-C8 distribution. 2. Greater occipital nerve neuralgia secondary to trauma from his injury. 3. Myofascial pain syndrome to the cervical paraspinal muscles. Plan: Recommend a cervical interspinal injection with trigger point injections under fluoroscopic imaging at the C7-C8 interspace. Also a left gr3ater occipital nerve block from a diagnostic therapeutic standpoint to relieve the irritability of the nerve at this region.

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

An analysis of the available records was performed. The compensable injury was xx/xx/xx. The secondary reports available state that he had normal EMG's/NCV tests performed in the past. The MRI of the cervical spine performed on December 21,

2011, reveals multiple areas of bony degenerative changes, with no evidence of spinal cord compression. These bony changes are not amenable to relief through cervical epidural steroid injection, with or without fluoroscopic control. In concurrence with the two previous UR reports on January 26, 2012, by MD, and on February 17, 2012, by DO, there is no objective evidence of a cervical radiculopathy.

There is also no report of the claimant's response to previous treatment. Thus the request for one cervical epidural injection under fluoroscopy is denied, based on the duration of time since the injury, as well as the claimant's age, and lack of documentation of a specific lesion amenable to the invasive treatment of one or more cervical epidural steroid injections. This denial is compatible with the ODG as reported below.

ODG:

Epidural steroid injection (ESI)	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. In a recent Cochrane review, there was one study that reported improvement in pain and function at four weeks and also one year in individuals with chronic neck pain with radiation. (Peloso-*Cochrane*, 2006) (Peloso, 2005) Other reviews have reported moderate short-term and long-term evidence of success in managing cervical radiculopathy with interlaminar ESIs. (Stav, 1993) (Castagnera, 1994) Some have also reported moderate evidence of management of cervical nerve root pain using a transforaminal approach. (Bush, 1996) (Cyteval, 2004) A recent retrospective review of interlaminar cervical ESIs found that approximately two-thirds of patients with symptomatic cervical radiculopathy from disc herniation were able to avoid surgery for up to 1 year with treatment. Success rate was improved with earlier injection (< 100 days from diagnosis). (Lin, 2006) There have been recent case reports of cerebellar infarct and brainstem herniation as well as spinal cord infarction after cervical transforaminal injection. (Beckman, 2006) (Ludwig, 2005) Quadriparesis with a cervical ESI at C6-7 has also been noted (Bose, 2005) and the American Society of Anesthesiologists Closed Claims Project database revealed 9 deaths or cases of brain injury after cervical ESI (1970-1999). (Fitzgibbon, 2004) These reports were in contrast to a retrospective review of 1,036 injections that showed that there were no catastrophic complications with the procedure. (Ma, 2005) 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. (Armon, 2007) There is evidence for short-term symptomatic improvement of radicular symptoms with epidural or selective root injections with corticosteroids, but these treatments did not appear to decrease the rate of open surgery. (Haldeman, 2008) (Benyamin, 2009) See the Low Back Chapter for more information and references. **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)**