IRO REVIEWER REPORT TEMPLATE -WC

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Notice of Independent Review Decision

Date: 9/25/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Epidural Steroid Injection under Fluoroscopy with Sedation (C5-C6 level; 62310 & 77003)

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

Board Certified Anesthesiologist

REVIEW OUTCOME:

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

☐ x 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:

Electrodiagnostic studies 07/21/11 and 05/19/11

Radiographs lumbar spine 01/03/12

MRI cervical spine 07/26/11

Clinical notes 06/27/12-09/13/12

Prior reviews 07/30/12 and 09/04/02

Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx and has been followed for complaints of pain in cervical spine radiating through the left shoulder. Electrodiagnostic studies on 07/21/11 reported a left sided C6 and reported a bilateral C6 and left sided C7 radiculitis. MRI of the cervical spine dated 07/26/11 revealed a mild disc bulge at C6-7. No central canal stenosis was present and no foraminal stenosis was identified. Clinical evaluation on 06/27/12 stated that the patient has had persistent neck pain and upper extremity pain despite oral medications and physical therapy. Physical examination revealed moderate paraspinal tenderness in the cervical spine with allodynia in the left upper extremity. Spurling's test was negative and there was slight diminished sensation to pin prick in a C5-6 distribution. Continuing medications included Neurontin 600mg TID and Cymbalta and Norco. The patient was reported to have good pain relief up to 30 or 40% with oral medications. The patient continued to be recommended for a cervical epidural steroid injection at C5-6. The request for a cervical epidural steroid injection C5-6 was denied by utilization review on 07/30/12 as there was a lack of documentation regarding the need for IV sedation and no level was specified. The request was again denied by utilization review on 09/04/12 as the patient appeared to have had prior epidural steroid injections with no improvements.

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

The request for an epidural steroid injection at C5-6 with fluoroscopy and sedation is not recommended as medically necessary based on the clinical documentation provided for review. Based on the clinical documentation provided for review, there is limited objective evidence to support a diagnosis of cervical radiculopathy at the C5-6 level. Although electrodiagnostic studies reveal evidence of radiculitis bilaterally at C6 into the left at C7 the patient's most recent physical examinations did not identify neurological deficits that would be consistent with the MR with the electrodiagnostic study findings. The continuing clinical documentation from Texas Anesthesia and Pain Management contained no further physical examinations. MRI studies of the cervical spine from 07/11 revealed no significant neurocompressive pathology at either C5-6 or C6-7 that would reasonably contribute to a diagnosis of cervical radiculopathy. The clinical documentation also does not establish that the patient has any significant needle phobias or anxiety that would require sedation as indicated by current evidence based guidelines. As the clinical documentation provided for review does not meet

guideline recommendations for the request, medical necessity is not established.

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

☐ x **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ x **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

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.