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Notice of Independent Review Decision

[Date notice sent to all parties]:

11/25/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Cervical Epidural Steroid Injection under fluoroscopy w IV sedation- outpatient

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Board Certified Anesthesiologist; Board Certified Pain Medicine

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:

Cover sheet and working documents
Initial pain evaluation dated 08/18/1997
Operative report dated 05/14/13
Follow up note dated 06/03/13, 08/23/13, 09/03/13, 09/10/13, 10/21/13, 10/14/13
Utilization review determination dated 09/23/13, 10/23/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. Initial pain evaluation dated 08/18/97 indicates that the patient has a longstanding, progressive reflex sympathetic dystrophy associated with sudomotor and vasomotor changes as well as progression into the head and neck associated with daily occipital and frontal headaches. The patient reports that she underwent carpal tunnel release in February 1995. There is a gap in the treatment records until operative report dated 05/14/13 which indicates that the patient underwent bilateral lumbar sympathetic block on this date. Note dated 06/03/13 indicates that the patient's pump is on 6.3 mg per day. Follow up note dated 09/03/13 indicates that

the patient is eagerly waiting to go ahead with cervical epidural blockade for acute exacerbation of her neck, shoulder and arm pain complaints. Per note dated 10/14/13, the patient's intrathecal pump is helping her maintain a general 50-60% pain relief.

Initial request was non-certified on 09/23/13 noting that there is no ODG support for this request. The purpose of any injections in CRPS is for diagnosis or to facilitate physical therapy. None of those are issues. Epidural blockade may be an alternative if there is evidence of coagulopathy, systemic infection or postsurgical changes and the patient has none of these. There is also the fact that the patient has not shown any lasting subjective, objective or functional improvement with all prior medical care including multiple prior injections and reports severe pain issues while on intrathecal Dilaudid. The denial was upheld on appeal dated 10/23/13 noting that per ODG Epidural infusions for sympathetic blockade are not recommended due to lack of evidence for use and high risk of complications including infection. As such given the lack of evidence to support the use of epidural infusions in the treatment of the claimant's condition the prior review is upheld and medical necessity has not been met.

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

Based on the clinical information provided, the request for cervical ESI under fluoroscopy w IV sedation outpatient is not recommended as medically necessary. The submitted records indicate that the patient presents with a longstanding history of reflex sympathetic dystrophy and has been treated with lumbar sympathetic blocks and intrathecal Dilaudid. The ***Official Disability Guidelines*** support cervical epidural steroid injections for the treatment of cervical radiculopathy. As noted by the previous reviewer, ODG Epidural infusions for sympathetic blockade are not recommended due to lack of evidence for use and high risk of complications including infection. Given the current clinical data, the request is not indicated as medically necessary.

IRO REVIEWER REPORT TEMPLATE -WC

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) Epidural steroid injections should be reserved for those who may otherwise undergo open surgery for nerve root compromise. (Bigos, 1999) Intramuscular injection of lidocaine for chronic mechanical neck disorders (MND) and intravenous injection of methylprednisolone for acute whiplash were effective treatments. There was limited evidence of effectiveness of epidural injection of methyl prednisolone and lidocaine for chronic MND with radicular findings. (Peloso-Cochrane, 2006) 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.