

IRO REVIEWER REPORT TEMPLATE -WC

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

[Date notice sent to all parties]:

10/02/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: APPEAL Cervical Transaminar Epidural Steroid Injection C6-7 #3-64479, 64480 APPEAL Cervical Transaminar Epidural Steroid Injection C6-7 APPEAL Epidurography, Radiology, Anesthesia

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:

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:

X-ray dated 11/30/11

Clinical notes dated 01/25/12, 04/13/12, & 05/07/12

MRI of the cervical spine dated 05/24/12

Workman's comp interim report of examination dated 10/11/12

Clinical note dated 11/27/12

Procedural note dated 12/12/12

Clinical note dated 01/23/13

Functional capacity evaluation dated 01/28/13

Procedural note dated 03/01/13

Clinical notes dated 03/27/13 & 07/10/13

Previous adverse determinations dated 07/25/13 & 08/27/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his cervical region. The x-ray report dated 11/30/11 revealed decreased disc space at C6-7 along with foraminal encroachment at C3-4 and C5-6 on the left. Decreased motion was noted on flexion and extension views. The clinical note dated 01/25/12 indicates the patient rating his cervical region pain as 6-9/10. However, the patient did note an increase in pain to 9/10 when moving his upper extremities. The note does mention the patient utilizing Vicodin for pain relief. Upon exam, mild to moderate tenderness was noted at the C5, C6, and C7 paraspinal musculature on the right. Range of motion was noted to be diminished throughout the cervical region to include 40 degrees of flexion, 40 degrees of extension, 20 degrees of bilateral rotation, 10 degrees of right lateral flexion, and 20 degrees of left lateral flexion. The clinical note dated 04/13/12 indicates the patient stating the initial injury occurred when he reached above a rack causing him to be pinned. The patient subsequently was transported to the emergency room where he was discovered to have 9 broken ribs as well as a pneumothorax. The patient continued with constant aching and pain in the cervical region. The clinical note dated 05/07/12 indicates the patient complaining of neck pain with radiation of pain into the upper shoulders. Intermittent numbness was also noted in the forearm and hands. The clinical note dated 11/27/12 indicates the patient rating his pain as 7/10. The procedural note dated 12/12/12 mentions the patient having undergone an epidural steroid injection in the cervical region. The clinical note dated 01/23/13 indicates the patient having 50% relief from the C6-7 translaminal epidural injection. The patient continued to rate his pain as 9/10 at that time. Radiating pain continued in the upper extremities. The functional capacity evaluation dated 01/28/13 indicates the patient able to demonstrate a medium to heavy physical demand level. The procedural note dated 03/01/13 indicates the patient undergoing a 2nd epidural injection at the C6-7 level. The clinical note dated 03/27/13 mentions the patient reporting 100% relief of pain following the 2nd injection. The note does mention the patient having undergone conservative therapies. The clinical note dated 07/10/13 mentions the patient rating his pain as 6/10 at that time. The patient was recommended for a 3rd cervical epidural injection at that time.

The previous utilization review dated 07/25/13 resulted in a denial as no information was submitted confirming the patient's radiculopathy.

The utilization review dated 08/27/13 resulted in a denial as the patient was noted to have undergone 2 previous epidural injections whereas guidelines recommend no more than 2.

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

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The documentation submitted for review elaborates the patient complaining of cervical region pain with radiating pain into the upper extremities. An epidural steroid injection would be indicated provided the patient meets specific criteria to include a positive response to a previous epidural injection and the patient is noted to have undergone no more than 1 previous epidural steroid injection to date. The clinical notes mention the patient having undergone 2 cervical epidural injections at the C6-7 level. Current research does not support a series of 3 injections in either diagnostic or therapeutic phase. Therefore, no more than 2 epidural steroid injections are recommended. As such, the request for a 3rd C6-7 epidural steroid injection is not supported.

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

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

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) Quadriplegia 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;

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- (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.