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Notice of Independent Review Decision

DATE: April 17, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient Cervical Epidural Steroid Injection (ESI) at C4-C5 and C6-C7 (cervical ESI Via Catheter Right C4-C5 to C6-C7 Coverage).

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

The reviewer is certified by the American Board of PM/Occupational Medicine with 34 years of experience.

REVIEW OUTCOME:

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

Overturned (Disagree)

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured at work on xx/xx/xx.

11/21/12: The claimant was evaluated. She presented with pain to the right wrist, headaches, mid and lower back pain, bursted lip, and sore jaw with pain level at 6/10 after a physical altercation with a male offender. She complained of decreased range of motion in the cervical spine with a pain level of 5/10. The pain radiated into the arms. She reported numbness and tingling in the upper extremities bilaterally and bilateral upper extremity weakness. She complained of headaches. On physical exam, she had decreased range of motion of the cervical spine in all planes. She had muscle spasm along the bilateral paraspinal muscles and trapezius muscles bilaterally. She had tenderness to palpation in the cervical spine. She had decreased right TMJ range of motion. Review of cervical spine x-rays was negative for fracture or dislocation. **DIAGNOSIS:** Right Neck Sprain. Concussion with no loss of consciousness. Right TMJ disorder. **RECOMMENDATIONS:** Physical therapy evaluation and treatment of cervical spine and right wrist. She was given Motrin, Robaxin, and Ultracet. She was

given a cervical collar and right wrist brace.

11/26/12: The claimant was evaluated. She reported being struck several times in the face during a physical altercation while at work. She reported having pain in the jaw, right wrist, neck, and headaches. On palpation/mobility testing, she demonstrated limited mobility of the cervical spine into right rotation and also limited opening of the right facet joint of C-Spine levels C3-C6. **ASSESSMENT:** Patient presents with s/s consistent with MD diagnosis. She demonstrates pain in the right wrist, cervical spine, and right TMJ, weakness in the right wrist, and limited mobility of the right wrist and C-spine secondary to right wrist and cervical spine sprain/strain. **FUNCTIONAL DEFICITS:** Lifting, pushing, pulling, repetitive right UE motion, chewing on right side. **GOALS:** Independent and compliant with

HEP. Patient to demonstrate ability to lift 5# with right hand from table to shoulder height. Patient to lift 15# from floor to shoulder height with 0-2/10 pain and good form. Patient to demonstrate ability to perform 45 minutes cont. UE activity without exacerbation of symptoms and 0-2/10 pain. DISCHARGE PLAN: 2 weeks. Independent and compliant with an HEP. Return to prior level of function. 100% achievement with current functional goals. She underwent PT and responded well to cervical spine PROM and STM to paraspinals. She reported decrease in soreness of neck. She stated fatigue upon completion of therapy today but no increase in pain.

11/27/12, 11/28/12, 12/03/12, 12/05/12, 12/06/12, 12/11/12, 12/13/12, 12/14/12, 12/19/12, 12/26/12, 12/28/12, 12/31/12, 01/02/13, 01/07/13, 01/08/13: The claimant underwent physical therapy treatment to the cervical spine and right wrist. On 12/13/12, she "responded good to treatment today. Continues to show improvement as less c/o headaches this week. No change in clinical presentation of the patient's right wrist." On 12/19/12, the claimant stated that her "neck felt better after manual therapy; less restriction through AROM." On 01/02/13, she was able to perform upright trunk positioning with static and dynamic activities to assist with overall mobility. On 01/07/13, her cervical tone was improved, low sensitivity to STM and MWM. On 01/08/13, the claimant was able to perform upper extremity functional activity with exacerbation. She left the clinic before consulting PT staff for further excises/interventions and she could not get the manual therapy that was beneficial before. She was pain focused and anxious about her ongoing cervical pain.

12/07/12: The claimant was evaluated. She stated that her symptoms had remained the same. She reported a pain level of 5. On physical exam, she continued to have decreased cervical range of motion in all planes. Trapezius muscle spasm was noted bilaterally. Tenderness to palpation remained the same. RECOMMENDATIONS: Continue PT. Medication: Motrin, Robaxin, Ultracet. Right wrist brace. Referral to psychologist post traumatic stress disorder. Cervical spine MRI without contrast. Right Wrist MRI without contrast.

12/18/12: MRI Cervical Spine report interpreted. IMPRESSION: There is mild spinal canal stenosis at the C3-C4, C4-C5, and C5-C6 levels. The spinal canal is 9 mm in AP dimension at these levels. This is due primarily to 2-3 mm protrusions/herniations. The spinal cord is contacted and partially deformed, most pronounced at the C4-C5 level. The spinal cord itself displays normal signal at these three levels. There is also evidence for a posterior annular tear with a high intensity zone at C5-C6, which could result in discogenic pain suggestive an acute finding. There is a 2 mm disc protrusion/herniation centrally at the C6-C7 level. The anterior CSF space is partially effaced. The spinal canal is borderline stenotic at 1 cm.

01/03/13: The claimant was evaluated. She complained of painful spasms of her right neck and facial pain. She denied numbness, tingling or paresthesias of the face. She denied ocular or visual deficits. She denied vertigo. She stated that her cervical symptoms remained the same. She reported a pain level of 5. She

stated that the numbness and tingling had resolved and her upper extremity weakness had resolved. She stated that her headaches remained the same. On physical exam, she had decreased cervical range of motion in all planes. Side bending remained the same. Rotation remained the same. Flexion was improved. Extension remained the same. Trapezius muscle spasm was noted right sided. Tenderness to palpation remained the same. RECOMMENDATIONS: Continue PT. Medications: Motrin, Robaxin. Wait for approval of epidural injection.

01/09/13: The claimant was evaluated. She stated that her cervical spine symptoms had increased. She reported a pain level of 8. She stated that her range of motion had decreased, radiating pain had increased, numbness and tingling had increased, and upper extremity weakness had increased. She stated that her headaches had resolved. On physical exam, she continued to have decreased cervical range of motion in all planes. She had muscle spasm along the paraspinal muscles – increased. Trapezius muscle spasm was noted bilaterally. Tenderness to palpation was increased. RECOMMENDATIONS: Referral to orthopedic surgeon – ESI cervical ortho.

01/29/13: The claimant was evaluated. noted that “of particular interest are the changes that are seen at the C4-C5 and C5-C6 levels where the surface of the cord is lightly contacted from the disc protrusions there that are described as 2-3 mm deep with associated ligamentum thickening as well. There is slight deformation of the cord described at C4-C5, but the cord substrate itself has a normal signal intensity at that level. As well, similar findings are described at C3-C4, but the degree of disc protrusion is not quite as severe, being described as 1-2 mm. The C2-C3 disc also demonstrates some loss of normal moisture content. The C7-T1 disc is the only disc that the radiologist interprets as normal.” The claimant described numbness and tingling that was only intermittently present that affected the index and third finger on the right hand periodically. She denied any weakness of the arm. She denied any left-sided symptoms. She complained of spasms in the neck and shoulder area. She reported a tendency to lose grip strength periodically. On physical exam, cervical muscle tension was increased on both sides of the midline, right side slightly more than left, particularly in the trapezius. She had some mild triggering at the base of the skull on the right. Cervical Lhermitte’s sign was positive for radicular dysesthesias. It appeared to be in the C7 distribution, possibly C6. Cervical range of motion was observed and appeared to demonstrate moderate restriction in movement largely because of symptom avoidance. RUE: Strength was intact in all myotomes, no obvious atrophy. She did have to make a more concerted effort with her right C7 innervated muscles, however, which “may be a subtle form of weakness.” LUE: Normal strength in all myotomes, no obvious atrophy. Distal reflexes showed no hyperreflexia. She did have one beat of clonus in her left ankle as compared to none on the right, which was likely a trivial finding. Upper extremity reflexes were symmetrical at 2-/2 throughout. COMMENTS: The patient appears to have sustained a significant injury to her cervical spine. A cervical epidural steroid injection might calm the symptoms a great deal, but it will not restore the disc protrusions to their previous positions I suspect to any significant degree. It might help the patient’s symptoms a great deal however. She may ultimately require

cervical surgery to remedy the situation long term, which the patient would like to avoid as would her doctors. I am only authorized to evaluate the patient today. My official opinion is that she needs to be considered for a cervical epidural injection followed by further conservative treatment to try to reduce the size of the disc protrusions that she has. If she fails to achieve long-term remission of her symptoms from that, then she may need a surgical evaluation. PLAN: Ibuprofen, Robaxin, Tramadol. Cervical ESI via catheter. UDS. wrote a letter stating, "The patient I think would benefit from an epidural steroid injection to soothe the nerve symptoms that she has had and resolve her neck pain."

02/05/13: UR performed. RATIONALE: The case does not meet the requisite ODG criteria for radiculopathy for an epidural steroid injection. The guides note: Radiculopathy must be documented. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, pages 382-383. (Anderson, 2000). Per the AMA guidelines, 5th Edition: Radiculopathy (page 382-383) is defined as significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots. The diagnosis requires a dermatomal distribution of pain, numbness, and/or paresthesias in a dermatomal distribution. A root tension sign is usually positive. The diagnosis of herniated disc must be substantiated by an appropriate finding on an imaging study. The presence of findings on an imaging study in and of itself does not make the diagnosis of radiculopathy. There must also be clinical evidence as described above. For the neck, the guides cite: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. At present, the records and the evidence-based citations do not support certification of the request.

02/08/13: The claimant was evaluated. In the cervical spine, she reported that overall her symptoms had decreased. She reported a pain level of 7. She reported that range of motion had increased, radiating pain had decreased, and numbness and tingling had decreased. She reported that her upper extremity weakness had decreased and her headaches had resolved. On physical exam of the cervical spine, she continued to have decreased range of motion in all planes. Muscle spasm along the paraspinal muscle decreased. Trapezius muscle spasm noted bilaterally. Tenderness to palpation decreased. PLAN: No PT at this time. Medication: Motrin, Robaxin, Ultracet. Decrease pain, increase ROM. PT denied, appealed, denied as of 01/21/13. Referral to other specialist: Cervical ESI.

02/21/13: The claimant was evaluated. references the UR performed stating that there were no imaging done. stated that "this is simply not true. She has had both x-rays and an MRI of the cervical spine which document disc disease present consistent with the patient's distribution of symptoms. She also has a positive nerve root tension sign in the form of a positive Lhermitte's sign, which induces radicular symptoms in the same distribution as her primary complaints. She has normal strength and normal reflex findings. She reports subjective numbness and tingling, but we were not able to document the presence of a sensory deficit at her initial evaluation." noted that the claimant had failed to

respond to conservative treatment strategies. He stated that "in my mind, there is no better candidate for an injection than this patient. Her physical exam could be slightly stronger with respect to a sensory deficit or diminished reflex findings or a motor deficit, but the fact of the matter is that patient who have minimal motor and reflex changes and predominantly sensory symptoms are those who typically have the best response to an injection. The reason for that is because the nerve root is not as severely impinged in those scenarios." On physical exam of the head and neck, she had stable findings. Lhermitte's sign continued to be positive in a C7 distribution of the right arm. Sensation to light touch testing continued to not betray any sensory deficit during the exam. However, tingling was elicited by the Lhermitte's sign test, "which in my mind is the functional equivalent of a sensory deficit to light touch testing." COMMENTS: The patient's physical exam is essentially unchanged. I would not expect it to be any different at this juncture. The patient is a very good candidate for injective therapy. If this is not approved, the only options that remain for her is to just put up with the symptoms, which is not in her best interest long term, or see a surgeon. I think opinion is in error and it appears to be based on less than a full set of the facts. I have instructed my staff to make sure that whoever the peer to peer doctor is on this gets a complete set of records, even if we have to send them to him ourselves. I believe the insurance carrier probably did not send him all of the records, particular the imaging studies.

02/28/13: UR performed. RATIONALE: On exam, she has a positive Lhermitte's sign at C7 on the right. Her MRI shows signs at C3-C4 to C6-C7. At C4-C5 and C6-C7, the surface of the cord is lightly contacted. The pathology at C6-C7 is not described. C7-T1 is normal. At the C6-C7 level, she has a 2 mm disc protrusion to the right. At the time of her first visit, she had C7 symptoms into her hand. This request is for a three-level injection. The current recommendation is for a maximum of two-levels of injection. The only clinical pathology noted is at C6-C7. An ESI is not a recommendation for stenosis without evidence of radiculopathy. The primary reason for non authorization is that the injection is at three levels. There is no other evidence of pathology other than stenosis at C5-C6. If this is an adhesiolysis procedure, this is not recommended as per the ODG.

03/08/13: The claimant was evaluated. She stated that overall her symptoms had decreased. She reported a pain level of 6, range of motion had remained the same, radiating pain had decreased, and numbness and tingling had decreased. Her upper extremity weakness had remained the same. On physical exam, she continued to have decreased range of motion in all planes. Muscle spasm along the paraspinal muscle remained the same. Trapezius muscle spasm was noted bilaterally. Tenderness to palpation had decreased. DTRs were normal. Sensation was normal. Upper extremity muscle strength was normal. Cervical spine MRI demonstrated C3-C4 disc protrusion and C5-C6 annular tear. RECOMMENDATIONS: No physical therapy at this time. Medication: Motrin, Robaxin, Ultracet. Follow Work Restrictions.

03/21/13: The claimant was evaluated. noted that the request for cervical ESI had been denied. He stated, "It appears that they are under the impression that I

am asking for 3 injections at 3 separate levels. That is not the case. I am asking for a single injection that will cover three levels that is delivered through a catheter that allows us the ability to spread the drug over a larger field.” He commented that the claimant’s symptoms were still radicular in nature in the C7 distribution on the right. She complained of muscle aches, back pain, stiffness, muscle cramps, numbness, tingling, weakness, and headaches. On physical exam, Lhermitte’s sign was positive in a C7 distribution of the right arm. Right upper extremity strength was intact all myotomes with no obvious atrophy. She did have to make a more concerted effort with her right C7 innervated muscles however. She had one beat of clonus in her left ankle as compared to none on the right, which was likely a trivial finding. Upper extremity reflexes were symmetrical, grading 2-/2 throughout. Light touch did not betray any sensory deficit during the exam. However, tingling was elicited by the Lhermitte’s sign test, which stated was the functional equivalent of a sensory deficit to light touch testing. She was given prescriptions for ibuprofen, Robaxin, and Tramadol.

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

The previous adverse decisions are overturned. The clinical findings suggest that there is a correlation between the radiographic findings and radicular findings on the right side. ODG criteria require radiculopathy documented by physical exam and corroborated by imaging studies, which the claimant meets. She was shown on physical exam to have positive Lhermitte’s sign with radiculopathy in a right C6 and C7 distribution. Her MRI dated 12/18/12 was positive for spinal canal stenosis at the C3-C4, C4-C5, and C5-C6 levels primarily due to 2-3 mm disc protrusions/herniations. In addition, there was an annular tear at C5-C6 and a disc protrusion/herniation at C6-C7. In his 03/21/13 notes, states that he was “asking for a single injection that will cover three levels that is delivered through a catheter that allows us the ability to spread the drug over a larger field.” As per the Physician Order written on 02/26/13, the request is confirmed as “Cervical ESI via Catheter. Levels: Right C4-C5 to C6-C7 Coverage.” This would meet ODG criteria as it is a single injection. Therefore, the request for Outpatient Cervical Epidural Steroid Injection (ESI) at C4-C5 and C6-C7 (Cervical ESI via Catheter Right C4-C5 to C6-C7 coverage) meets ODG criteria.

ODG:

<p>Epidural steroid injection (ESI)</p>	<p>Criteria for the use of Epidural steroid injections, therapeutic: <i>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.</i></p> <p>(1) Radiculopathy must be documented by physical examination <u>and</u> 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) 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.</p> <p>(5) No more than two nerve root levels should be injected using transforaminal blocks.</p>
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	<p>(6) No more than one interlaminar level should be injected at one session.</p> <p>(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.</p> <p>(8) Repeat injections should be based on continued objective documented pain and function response.</p> <p>(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.</p> <p>(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.</p> <p>(11) Cervical and lumbar epidural steroid injection should not be performed on the same day.</p> <p>Criteria for the use of Epidural steroid injections, diagnostic:</p> <p>To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:</p> <p>(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;</p> <p>(2) To help to determine pain generators when there is evidence of multi-level nerve root compression;</p> <p>(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;</p> <p>(4) To help to identify the origin of pain in patients who have had previous spinal surgery.</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
- AHCP- 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)