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Notice of Independent Review Decision

[Date notice sent to all parties]:

02/01/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Right C7/T1
Cervical ESI injection

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

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
Utilization review determination dated 11/01/12, 11/07/12
Report of medical evaluation dated 11/01/12
Encounter notes dated 08/26/10, 09/02/10, 09/10/10, 09/15/10, 09/24/10, 10/07/10
EMG/NCV dated 03/22/11
Physical therapy daily note dated 09/17/10, 09/22/10, 09/23/10, 09/29/10
MRI cervical spine dated 12/08/10
MRI lumbar spine dated 10/29/10

MRI thoracic spine dated 10/29/10

Laboratory report dated 11/03/10, 12/06/11, 09/19/12, 09/21/12

Functional capacity evaluation dated 10/10/12

Designated doctor evaluation dated 02/09/11, 05/10/11, 01/11/12, 07/02/12

MRI right shoulder dated 01/24/11

Office visit note dated 02/04/11, 03/09/11, 03/31/11, 04/29/11, 05/31/11, 07/28/11, 08/11/11, 10/04/11, 10/24/11, 11/01/11, 11/16/11, 12/06/11, 12/07/11, 12/09/11, 12/14/11, 12/16/11, 01/06/12, 01/10/12, 01/13/12, 02/21/12, 04/27/12, 09/19/12, 10/10/12, 10/24/12, 11/07/12, 11/21/12, 12/05/12

Daily progress note dated 12/02/11, 12/06/11, 12/12/11, 12/15/11, 12/27/11, 12/28/11, 01/04/12, 01/05/12

Operative report dated 09/21/11

Health insurance claim form

Initial interview dated 04/21/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the claimant was struck in the right face area and her neck got twisted at the same time. The patient completed a course of physical therapy. MRI of the thoracic spine dated 10/29/10 revealed no central canal stenosis, compression fracture, bone marrow edema or ligamentous soft tissue injury. MRI of the cervical spine dated 12/08/10 revealed very slight disc bulge at C6-7. At C7-T1 there are no significant abnormalities seen. EMG/NCV dated 03/22/11 revealed evidence of C5 and C6 radiculopathy on the right and left. The patient underwent cervical translaminar epidural steroid injection at C7-T1 on 04/29/11. Designated doctor evaluation dated 05/10/11 indicates that the patient has not reached MMI noting that her cervical spine treatment just began on this date. Follow up note dated 05/31/11 indicates that the patient reports an initial 10% reduction in her pain for 3 days. The patient mentions that the injection to her neck did not help. The patient underwent right shoulder surgery consisting of arthroscopy, acromioplasty, extensive debridement of the subacromial space, bursectomy, and labral repair on 09/21/11 followed by a course of postoperative physical therapy. Designated doctor evaluation dated 07/02/12 indicates that diagnoses are facial contusion; cervical sprain/strain; C5-6 disc protrusion; right shoulder sprain/strain; and labral tear/supraspinatus injury. The patient has not reached maximum medical improvement. The patient underwent cervical epidural steroid injection on 10/10/12. Follow up note dated 10/24/12 documents 60% relief. Report of medical evaluation dated 11/01/12 indicates that the patient is not at MMI. Note dated 11/07/12 reports greater than 60% relief. Office visit note dated 12/05/12 indicates on physical examination there is decreased cervical range of motion.

Initial request for right C7-T1 cervical epidural steroid injection was non-certified on 11/01/12 noting that as the relief did not last the recommended 6-8 weeks and as the radiculopathy on EMG/NCV was at C5-6, there is not sufficient documentation or rationale for one outpatient right cervical epidural steroid injection at C7-T1. The

denial was upheld on appeal dated 11/07/12 noting that there is rarely evidence of herniation at C7-T1 and there is no evidence of this on diagnostic study. This distribution of symptoms is not in this dermatome. The request is denied due to lack of diagnostic documentation to support this injection.

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 right C7-T1 cervical epidural steroid injection is not recommended as medically necessary. The submitted MRI of the cervical spine dated 12/08/10 revealed very slight disc bulge at C6-7. At C7-T1 there are no significant abnormalities seen. EMG/NCV dated 03/22/11 revealed evidence of C5 and C6 radiculopathy on the right and left. The patient underwent epidural steroid injection on 10/10/12; however, the submitted records fail to document at least 50% pain relief for at least 6-8 weeks as required by the Official Disability Guidelines prior to the performance of repeat epidural steroid injection.

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

ODG Neck and Upper Back Chapter

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.
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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](#)) Quadripareisis 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.