

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

Date notice sent to all parties:

06/06/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Appeal right Cervical TFESI at C4-5 C5-6 64479 64480 72275 (99144 iv sed/PNR)

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

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:

Clinical notes dated 12/28/11 – 05/05/13
MRI of the cervical spine dated 10/06/11
MRI of the right shoulder dated 10/08/11
Electrodiagnostic studies of the upper extremities dated 12/16/11
Radiology report dated 12/28/11
MRI of the cervical spine dated 04/03/12
Operative report dated 08/29/12
Operative report dated 12/19/12
Previous utilization reviews dated 04/10/13 & 05/03/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury regarding her cervical region. The electrodiagnostic studies completed on 12/16/11 revealed moderate right carpal tunnel

syndrome. No evidence of a cervical radiculopathy was noted in either upper extremity. The clinical note dated 12/28/11 details the patient stating the initial injury occurred when she was lifting merchandise to include heavy boxes. The patient noted pain at the right superior trapezii region. The radiology report dated 12/28/11 revealed degenerative disc disease at C5-6, C6-7, and C7 T1. The clinical note dated 01/07/12 details the patient continuing with 8/10 cervical pain. The clinical note dated 02/22/12 details the patient continuing with cervical region pain. The patient was able to demonstrate full range of motion at the shoulder. The patient further demonstrated 5/5 strength in both upper extremities. Tingling was noted in both forearms. The patient was recommended to initiate physical therapy at that time. The clinical note dated 03/26/12 details the patient having undergone physical therapy with no significant benefit. Upon exam, sensation was noted to be intact at that time. Reflexes were noted to be symmetric in both upper extremities. Strength was 5/5 throughout both upper extremities. The MRI of the cervical spine dated 04/03/12 revealed disc space narrowing at C5-6 and C6-7. No cord compression was noted. The clinical note dated 05/01/12 details the patient utilizing Lyrica and Zanaflex for ongoing pain relief. The patient continued with complaints of tingling in both forearms. The operative report dated 08/29/12 details the patient undergoing a selective nerve root block at C6-7 with fluoroscopic guidance. The clinical note dated 10/01/12 details the patient reporting a 20% improvement on the right and a 10% improvement on the left regarding the previous injection. The patient continued with numbness in the lower portion of the neck and tingling in the outer left arm. The operative report dated 12/19/12 details the patient undergoing a C6-7 selective nerve root block bilaterally. The clinical note dated 03/28/13 details the patient continuing with cervical region pain. The note details the patient reporting some improvement regarding her arm spasms and neck pain following the injection. No radicular symptoms were noted. The designated doctor evaluation dated 04/16/13 details the patient's cervical flexion to be within normal limits. The patient did demonstrate 20% reduction in extension as well as bilateral rotation.

The previous utilization review dated 04/10/13 resulted in a denial for a C4-5 and C5-6 epidural injection secondary to a lack of neurologic deficits indicating a radiculopathy component in the cervical region. Additionally, it was unclear at that time if the patient completed a full course of conservative treatments.

The utilization review dated 05/03/13 for a cervical epidural injection at C4-5 and C5-6 resulted in a denial secondary to no significant findings suggesting a cervical radiculopathy.

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

The documentation submitted for review elaborates the patient complaining of cervical region pain. An epidural steroid injection would be indicated in the cervical region provided the patient meets specific criteria to include a radiculopathy component noted by exam and confirmed by imaging studies. No information was submitted regarding the patient's significant exam findings indicating a radiculopathy component manifested by strength, sensation, or reflex changes. Additionally, it is unclear if the patient has previously completed a full course of conservative therapy as no information was submitted regarding the patient's completion of any physical therapy sessions or dates of the patient's involvement with physical therapy. Given that no information was submitted regarding the patient's confirmation of a radiculopathy component in the C4, C5, or C6 distribution and taking into account that no information was submitted regarding the patient's completion of all conservative treatments, this request is not indicated. As such, it is the opinion of the reviewer that the request for a cervical transforaminal epidural steroid injection at C4-5 and

C5-6; 64479, 64480, 72275 is not recommended as medically necessary.

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

Official Disability Guidelines, Neck and Upper Back Chapter, Online Version

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;
- (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.