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Notice of Independent Review Decision

Date notice sent to all parties:

September 3, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Appeal Outpatient C5-6 Cervical Epidural Steroid Injection

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

Board Certified Orthopedic Surgeon

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
Handwritten new injury report dated 01/28/13
Handwritten patient follow up note dated 01/31/13
Radiographic reports dated 02/08/13
Orthopedic consult dated 02/08/13, 05/17/13, 07/12/13
Utilization review determination dated 06/17/13, 08/08/13
MRI cervical spine dated 03/01/13
Reference material
EMG/NCV dated 04/03/13
Office note dated 03/19/13, 04/26/13, 07/15/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. The patient's right foot was caught. She twisted her left knee, but fell onto her right knee and fell on her outstretched left hand. MRI of the cervical spine dated 03/01/13 revealed at C5-6 there is a central disc protrusion (herniation) measuring 3 mm producing mild central canal stenosis. EMG/NCV dated 04/03/13 revealed findings consistent with mild left median nerve neuropathy and entrapment at the wrist; there was no evidence suggestive of peripheral neuropathy, myopathy, neuromuscular junction disorder or acute cervical radiculopathy. Orthopedic report dated 05/17/13 indicates that the patient underwent corticosteroid injection which gave her approximately 2 weeks of relief in her carpal tunnel region. On physical examination cervical region has moderate range of motion in all directions and positive axial compression test. She had a positive Spurling's sign reproducing symptoms in the left upper extremity. Motor strength is weaker on the left when compared to the right, mostly due to her left wrist, left elbow and left shoulder. Note dated 07/15/13 indicates that pain level is 7/10. On physical examination upper extremities strength is rated as 5/5 throughout. Deep tendon reflexes are 2/4 bilaterally. Reflexes and distal sensation are normal. Spurling's test caused cervical pain bilaterally.

Initial request for outpatient C5-6 cervical epidural steroid injection was non-certified noting that there is limited understanding of any compressive etiology noted on MRI of the cervical spine with electrodiagnostic studies negative for any formal compressive cervical radiculopathy. Per appeal note dated 07/12/13, the patient's physical examination is positive for radiculopathy. The denial was upheld on appeal dated 08/08/13 noting that electrodiagnostic studies did not indicate evidence of radiculopathy stemming from the cervical spine. Furthermore, on the most recent examination narrative dated July 15, 2013, there is no evidence of cervical radiculopathy. It should be noted that on this most recent examination narrative the patient is denying numbness or tingling. Furthermore, examination has revealed 5/5 bilateral and symmetrical upper extremity strength along with 2/4 and symmetrical upper extremity reflexes.

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 outpatient C5-6 cervical epidural steroid injection is not recommended as medically necessary. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. MRI of the cervical spine dated 03/01/13 fails to document any significant neurocompressive pathology, and the submitted EMG/NCV dated 04/03/13 is negative for cervical radiculopathy. The most recent physical examination submitted for review dated 07/15/13 documents 5/5 strength in the bilateral upper extremities, 2/4 and symmetrical upper extremity reflexes. Sensation is noted to be

intact. Given that the submitted records fail to establish the presence of active cervical radiculopathy, the requested epidural steroid injection is not indicated as medically necessary.

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. 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
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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.