

# Vanguard MedReview, Inc.

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## Notice of Independent Review Decision

November 20, 2014

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical epidural steroid injection C7-T1 Qty:1.00, Fluoroscopy Qty: 1.00, MOD CS by Same Phys, 5 yrs + Qty: 1.00

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

This reviewer is a Board Certified Physical Medicine and Rehabilitation doctor with over 16 years of experience.

### 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.

### PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx in her left knee, right shoulder and low back after slipping and falling.

11/22/2013: Office Visit. **HPI:** The patient reports left knee and low back is only mild soreness. Wearing heating pad and less movement helps her pain. She is working regular duty. Pain is level 6/10. Seen at TMFH, x-rays taken and meds prescribed. **Assessment:** Sprained left knee, Lumbar strain, Rotator cuff tendonitis RT, Bicipital tendonitis-Right shoulder **Plan:** Meloxicam 15mg Tablet, take 1 tab by mouth, every day, for 30 days. Qty: 30 tab, no refills. Therapy: Continue meds, follow-up 3 weeks. Fit for work with restrictions. Light duty work release.

12/13/2013: Office Visit. **HPI:** Pt reports no lt knee pain but states constant pain with her rt shoulder Taking the pain med helps her pain. She is working light duty

and will start PT today. Pain scale is 4/10. **Assessment:** Neck sprain, sprained left knee-resolved, lumbar strain, rotator cuff tendonitis RT, Bicipital tendonitis – right shoulder, Cervical radiculopathy. **Plan:** Tramadol HCl Tramadol 50mg Tablet, take 1 tab by mouth, up to twice a day as needed for 30 days. Qty: 30, no refills. Continue PT, Follow up 3 weeks, Fit for work-light duty.

01/10/2014: Office Visit. **HPI:** Patient reports constant pain with her rt shoulder. She has been working light duty, but was terminated yesterday. Finishes PT today. Pain scale is 2. Having persistent weakness and ROM limitation especially with elevation of arm in abduction. **Assessment:** Neck sprain, sprained left knee-resolved, lumbar strain, rotator cuff tendonitis RT, Bicipital tendonitis-rt shoulder, cervical radiculopathy. **Plan:** An MRI of the right shoulder without contrast, an MRI if the cervical spine without contrast, continue current medication, follow-up for re-examination in 2 weeks, Fit for work-light duty.

01/17/2014: MRI of the cervical spine without IV contrast **Impression:** 1. Prominent disc protrusion or herniation into the left neural foramen at C5-6 appears likely to be compressing the left C6 nerve root but needs consideration clinically, as the patient's symptoms are described on the right. 2. Prominent disc protrusion at C4-5 has eccentric element to the right and appears to be causing fairly right neural foraminal stenosis that might be symptomatic in the right C5 nerve root distribution. 3. Broad-based posterior disc protrusion at C3-4 appears to be associated with substantial left neural foraminal narrowing. No cord compression is seen at any level. Correlation is needed clinically as to optimal overall follow-up.

01/28/2014: Office Visit. **HPI:** Pain is 3 today. She needs refills on her meds. Having persistent weakness and ROM limitation of rt shoulder. Also having pain in right side of cervical spine. Denies numbness or paresthesias into right hand/fingers. **Assessment:** Neck sprain with C4-5 disc protrusion and right C5 NF stenosis, sprained left knee, lumbar strain, rotator cuff tendonitis RT with full thickness tear of supraspinatous tendon, bicipital tendonitis-rt shoulder, cervical radiculopathy. **Plan:** Acetaminophen + hydrocodone bitartrate Norco 325mg-5mg tablet, take 1 tab by mouth, every day for 30 days. Qty 30, no refills. Meloxicam 15mg tab, take 1 tab by mouth every day for 30 days. Qty 30, no refills. Continue meds, follow up 1 month, Not fit for work-off for now.

02/05/2014: Office Visit. **HPI:** Patient complaints are headache in the occipital region which is dull/aching/boring. No excruciating headache. Headache lasting more than a week, of recent onset, and occurring several times each week. Headache not precipitated by etoh, not by eating certain foods, and not by certain medications. Headache worse when moving the head and relieved by reducing stimuli. Headache not associated with menarche, not with the menstrual cycle, and headache not preceded by depression. Headache not preceded by aura. Neck pain on both sides with right worse than left, increased by movement. Shoulder joint pain on the right. No pain in the left shoulder joint. Shoulder joint pain when actively moved, when passively moved, and improves during exercise, returns later. **Physical Findings:** Musculoskeletal System: Cervical Spine:

General/bilateral: The cervical spine showed tenderness on palpation of the spinous process of the C5, of the C6, of the C7, of the transverse process of the C2 bilaterally, of the C3 bilaterally, of the C4 bilaterally, flexion was abnormal, extension was abnormal, rotation to the right was abnormal, to the left was abnormal, lateral flexion to the left was abnormal, lateral flexion to the right was abnormal, showed pain elicited by motion had a foraminal compression test which caused pain to radiate to arm on same side to which head was rotated. Thoracic Spine: General/Bilateral: The thoracic spine exhibited no swelling, exhibited no induration, and exhibited no ecchymosis. The thoracic spine showed normal curvature. No tenderness on palpation of the thoracic transverse process, not of the spinous process, and not of the ribs and costal cartilage. The thoracic spine exhibited no spasm of the paraspinal muscles. Lumbar/lumbosacral Spine: General/bilateral: The lumbosacral spine indicated normal curvature.

**Assessment:** 1. Complete tear of the right rotator cuff tendon 2. Cervical facet syndrome. **Plan:** I discussed the treatment options with the patient. Her H&P is consistent with a combination of Upper Cervical Z joint mediated pain and Rt. Rotator cuff mediated pain. She hasn't responded to the PT. She has limited ROM and moderate to severe upper cervical Z joint mediated pain. She has no radicular symptoms. Her MRI mainly shows degenerative changes. I will proceed with Bilat. C2-4 MBB's with Marcaine. If she responds to the diagnostic blocks then I will consider a RF Neurotomy. She has a hx of Anxiety and have severe Needle phobia. I will request mild IVCS for the procedure. UDS ordered. Therapy: Special dr. services analysis of computerized data. Modify drug dosage-Hold NSAID's for inj. Follow-up post injection.

04/11/2014: Office Visit. **HPI:** Patient has done 3 weeks of PT. She states that all it did was flare up her pain. She is having more headaches. She hasn't the Rt shoulder surgery as of yet. **Assessment:** Complete tear of right rotator cuff tendon, cervical facet syndrome. **Plan:** She has done 3 weeks of PT. She states that her ROM is a bit better but her neck pain and headaches are worse. She has daily headaches. She is tired of hurting. She has no radicular symptoms. She isn't responding to the medications. I feel that the best approach would be diagnostic Bilat. C2-4 MBB's. If she responds to the diagnostic blocks then I will consider a RF Neurotomy. Rx. For fioricet. Therapy: Modify drug dosage- Hold NSAID's for inj. Home exercise program education. Follow-up post injection.

04/23/2014: Procedure Note. **Procedure:** Bilateral C2-C4 Medial Branch Blocks with dexamethasone under fluoroscopic guidance. **Assessment:** Post procedural Diagnosis: Cervical facet syndrome

05/02/2014: Office Visit. **HPI:** Patient is here for F/U post injection. She is S/P Bilat. C2-4 MBB. She reports 80% relief from procedure for 2-3 days then the pain started to return. She was headache free for 6 days then her symptoms quickly returned. **Physical Findings:** The cervical spine showed tenderness on palpation. The C5 spinous process was not tender on palpation, not of the C6 and not of the C7. The C2 transverse processes on both sides were tender on palpation, of the C3 bilaterally, and of the C4 bilaterally. The trapezius muscle was not tender on palpation and cervical spine flexion was normal. Cervical spine

extension was abnormal, rotation to the right was abnormal, to the left was abnormal, lateral flexion to the left was abnormal, lateral flexion to the right was abnormal, showed pain elicited by motion and had a foraminal compression test performed. A foraminal compression test did not cause pain to radiate to the arm on the same side to which the head was rotated. **Assessment:** Complete tear of right rotator cuff tendon, cervical facet syndrome. Therapy: Continue current medication, modify drug dosage-Hold NSAID's for inj., Follow-up visit post injection, not fit for work-off work for now. **Plan:** She responded to the C2-4 MBB's. She had 80% relief from the diagnostic Marcaine blocks. Therefore, I am confident that the majority of her neck pain is upper cervical Z joint mediated. She has been through a course of conservative treatment. I will proceed with Bilat. C2-4 RF Neurotomy. Therapy: Continue current medication, modify drug dosage-Hold NSAID's for inj., follow-up visit post injection, not fit for work, off for now.

05/27/2014: Procedure Note. **Procedure:** Bilateral C2-C4 Radio frequency ablation of the medial branches under fluoroscopic guidance. **Assessment:** Post procedural Diagnosis: Cervical facet syndrome.

06/19/2014: Office Visit. **HPI:** Patient is here for f/u post injection. She is s/p bilat. C2-4 RF Neurotomy. She reports 100% relief from procedure. She is doing much better however she isn't pain free. She underwent a rt rotator cuff repair and SLAP repair on June 10, 2014. She has started PT. She states that the rt shoulder and Trapezius region pain is bothering her the most. **Assessment:** Rotator cuff tendonitis RT with partial tear of supraspinatous tendon and SLAP lesion-S/P repair on June 10<sup>th</sup>, 2014, Cervical facet syndrome. **Plan:** She responded to the C2-4 RF Neurotomy. Her headaches are 100% better. She still has moderate sensitivity at the procedure site. She is starting PT for the rt shoulder surgery. I will ask the PT to address the sensitivity.

09/09/2014: Office Visit. **HPI:** Patient reports no lt knee pain, but she has intermittent rt shoulder pain today. Stretching and taking her meds helps. She isn't working at the time. Pain is a 3 today. **Physical Findings:** Musculoskeletal System: Shoulder: Right Shoulder: Right shoulder was examined near normal ROM, no instability. Normal neurovascular exam. Cervical Spine: General/bilateral: The cervical spine exhibited a muscle spasm. Cervical spine flexion was normal. Cervical spine extension was abnormal, rotation to the right was abnormal, and to the left was abnormal. Cervical spine motion on lateral flexion to the left was normal. Cervical spine motion on lateral flexion to the right was abnormal and showed pain elicited by motion. Lumbar/Lumbosacral spine: The lumbosacral spine exhibited no tenderness on palpation of the transverse process. Neurodynamic tests of the lumbosacral spine were performed negative SLR bilaterally. **Assessment:** Neck sprain with C4-5 disc protrusion and right C5 NF stenosis, sprained left knee-resolved, lumbar strain, rotator cuff tendonitis RT with partial thickness tear of supraspinatous tendon and SLAP tear, bicipital tendonitis-right shoulder, cervical radiculopathy. **Plan:** Acetaminophen + hydrocodone bitartrate Norco 325mg-5mg tab, take one tab by mouth every day for 30 days. Qty: 30, no refills, Cyclobenzaprine hydrochloride 10 mg tab, take

one tab by mouth three times per day as needed for 30 days. Qty: 90 20-pack, refills 1. Special instructions: per muscle spasms.

09/19/2014: Office Visit. **HPI:** Pt continues to have moderate neck and rt shoulder pain. She is taking Norco QD and Flexeril TID PRN for the pain. **Physical Findings:** The cervical spine showed tenderness on palpation. The C4 spinous process was not tender on palpation. The C4 spinous process was tender on palpation, not of the C3 and not of the C4. Cervical spine flexion was normal, extension was normal and cervical spine rotation to the right was normal. Cervical spine rotation to the left was abnormal. Cervical spine motion on lateral flexion to the left was normal. Cervical spine motion on lateral flexion to the right was abnormal and showed pain elicited by motion. **Assessment:** Complete tear of right rotator cuff tendon, cervical radiculopathy-723.4 Vs. Cervical Facet Syndrome **Plan:** She is having more neck and shoulder pain. She has some pain radiating to the Rt. Deltoid region. Her shoulder pain has been addressed by surgery. She has been through an extensive course of PT. Her MRI is quite impressive. I will proceed with a C7-T1 ESI. Therapy: Modify drug dosage-Hold NSAID's for inj., follow-up visit post injection.

10/20/2014: UR. **Rationale for Denial:** The history and documentation do not objectively support the request for an ESI at level C7-T1. The ODG state "ESI may be recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Criteria for the use of Epidural steroid injections includes radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing and initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)." In this case, there is no clear objective evidence of radiculopathy at the level to be injected on physical examination and no EMG was submitted. There is no indication that she has failed all other reasonable conservative care, including physical therapy, or that this ESI is being offered in an attempt to avoid surgery. The MRI report does not indicate the presence of nerve root compression at the level to be injected. There is no indication that the claimant has been instructed in home exercises to do in conjunction with injection therapy. Therefore, the request for ESI C7-T1 is denied as it is not medically necessary and appropriate.

10/31/2014: UR. **Rationale for Denial:** The CA MTUS guidelines note that epidural injections can be considered when there is documentation of objective radiculopathy on physical examination, corroborating with diagnostic imaging, and failure of conservative measures. In this case, there are no objective findings on examination indicative of radiculopathy in the distribution of the requested injections, and imaging studies do not identify pathology at the requested level and there was no EMG/NCV study included for review. The patient reports pain does not radiate down the arm. Furthermore, laterality of the requested injection is not specified. Thus, the current request for appeal: ESI C7-T1 is denied.

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

The previous adverse determinations are UPHELD/AGREED UPON since there is no documented objective evidence of radiculopathy (with no documented provocative nerve root testing, nor neurological exam - sensory/motor/reflexes) correlating with imaging findings, nor correlating with requested level of injection. There is question regarding approach and lateralization of the requested injection. There is question of any available electrodiagnostic studies. There is question regarding continued current conservative measures, including compliance with home exercise program, activity modification and current medication regimen, especially given chronicity of the case. For these reasons, Cervical epidural steroid injection C7-T1 Qty:1.00, Fluoroscopy Qty: 1.00, MOD CS by Same Phys, 5 yrs + Qty: 1.00 is not medically necessary at this time and should be denied.

Per ODG:

### **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.

**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**
- AHCPR- 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)**