

Icon Medical Solutions, Inc.

11815 CR 452
Lindale, TX 75771
P 903.749.4272
F 888.663.6614

Notice of Independent Review Decision

DATE: April 9, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Translaminar Epidural Steroid Injection with Anesthetic Block and Fluoroscopic Guidance to Include CPT Codes 62310, 77003, 99144

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 Physical Medicine and Rehabilitation 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who injured her cervical and thoracic spine when lifting on xx/xx/xx.

04/26/13, 06/27/13, 07/26/13: The claimant was evaluated for right knee pain.

10/08/13: The claimant was evaluated. She complained to pain in the left side of the neck and upper back. She characterized the pain as deep, dull ache, burning, and radiating into the upper back. The pain was increased with daily living activities of pushing, pulling, overhead activities, and repeat movement of the cervical spine. It was noted that she had been treated with examination, medication management, and a brief course of physical therapy. The claimant was evaluated who recommended nonoperative treatment for her pain. On physical exam, she had bilateral point tenderness of the cervical paraspinals. ROM was reduced moderately in all ranges with pain at extreme. Strength of the

cervical spine was 4+ to 5-/5, reduced secondary to pain. Orthopedically, she showed positive foramen compression. Examination of the upper thoracic spine showed point tenderness more on the left than the right of the paraspinals, including rhomboid and levator scapula. DTRs in the upper extremities were +2/+4. Sensory exam was normal. Impression was cervical sprain-strain grade 2 and thoracic sprain-strain. PLAN: RTC 2 weeks. Maintain modified work status. Request additional PT. Referral for medication management. Order MRI of the cervical spine.

10/28/13: The claimant was evaluated. Physical exam, impression, and plan remained unchanged from 10/08/13.

11/07/13: MRI Thoracic Spine Report. IMPRESSION: No disc herniation, disc bulge, or spinal canal stenosis. No ligamentous injury visualized on sagittal STIR imaging. No evidence of vertebral body or posterior element fracture.

11/07/13: MRI Cervical Spine Report. IMPRESSION: Disc bulge and herniation at C3-C4 measuring 2 mm. Disc herniation also seen at C5-C6 as described above with bilobed appearance to the left and right of midline. Extension into the left neural foramen contributing to neural foraminal stenosis at C5-C6 also.

11/12/13: The claimant was evaluated. She noted that medication management had been helpful recently as well as continued stretching and use of heat packs and rest. On physical exam, she had positive foramen compression. There was a positive Soto-Hall for the upper thoracic spine. Palpation showed point tenderness of the cervical and upper thoracic paraspinals, more on the left than the right. There was a very tight musculature in this area with trigger point development. DTRs in the upper extremities were +2/+4. There was no sensory loss. She was to be referred to a physical medicine and rehabilitation specialist for EMG/NCV and determination regarding epidural steroid injections. Physical therapy was requested.

11/19/13: The claimant was evaluated. On his review of records, he noted that she was referred for PT and the first PT note on 08/05/13 documented left paracervical pain. The sixth session of therapy was completed on 08/19/13, and upper extremity range of motion was WNL, cervical ROM was WNL. The therapist noted that there was no change in her symptoms. Records reviewed dated 08/19/13 noted that her pain was the same, the medication was not working, and the therapy did not help. Examination showed that the spasms had resolved. On evaluation, he noted that the claimant still had pain. She noted that the physical therapy caused more pain and stiffness. She was noted to be seeing for message therapy, heat therapy, exercise, and trigger point injections. It was noted that the trigger point injection two weeks prior to the 11/19/13 visit provided some relief of the pain. On exam, she had mild reduction in cervical spine ROM secondary to subjective pain. There was diffuse subjective pain throughout the entire neck, trapezius muscle, left scapular region, and left parathoracic muscles. There was no evidence of paracervical muscle spasm present on palpation. Spurling's test was deferred because of the presence of significant pain

complaints with gentle light touch throughout the neck and left mid back. Strength and sensation were intact in the upper extremities. Reflexes were normal. There was no objective evidence of a cervical radiculopathy. Of note was that testing of the fingers and wrists distally caused an increase in left-sided neck and back pain.

12/09/13: The claimant was evaluated who noted that medication management, prior physical therapy, heat packs, and rest had been helpful to decrease some of her pain and discomfort. On exam, she had ongoing point tenderness of the cervical and upper thoracic paraspinals. There was trigger point noted throughout this tissue. There was restricted ROM moderately with pain at extreme. She was to continue with her last two physical therapy sessions.

01/09/14: The claimant was evaluated. She complained of headaches in addition to cervical and thoracic spine pain. She stated that hydrocodone greatly improved her symptoms. On exam, she had normal strength and reflexes. She had diffuse pain with palpation on the left side of her neck and nuchal areas down into the T1-T2 region with marked tenderness in the suboccipital and the upper cervical region. ROM C-Spine: 10 degrees in flexion, 30 degrees in extension, 20 degrees of right rotation, 10 degrees of left rotation, and 10 degrees of right and left lateral flexion. PLAN: Ice and heat to the neck. PT and rehab to the neck. Referral to pain management. Continue hydrocodone. Soft tissue injections pending, oral steroids pending, non-steroidals pending, migraine medicine pending, all of which were to be reviewed after was to see her.

01/13/14: EMG/NCV. IMPRESSION: The above electrodiagnostic study reveals evidence of a mild right carpal tunnel syndrome (medial nerve entrapment at wrist) affecting sensory components. Evidence of a mild left carpal tunnel syndrome affecting sensory and motor components. Evidence of a mild C5/C6 nerve root irritation on the left.

01/27/14: The claimant was evaluated. On exam, she had positive foramen compression and minimally positive Soto-Hall for the upper thoracic spine. She had point tenderness with trigger points in the left cervical paraspinals, trapezius, levator scapula, and posterior scalenus musculature. There was minimal point tenderness and a trigger point in the left suboccipital. Strength was reduced secondary to pain showing 4+ to 5-/5. Reflexes were maintained at +2/+4. Sensation was intact. ROM of the cervical spine showed moderate restriction in all ranges with pain at extreme. She was to return in 30 days.

02/03/14: The claimant was evaluated. It was noted that on 10/29/13, gave the patient an injection of Marcaine and Depo-Medrol into the thoracic region along the inferior aspect of the scapula and injected trigger areas in the rhomboid muscle bundle group. On physical exam, there was no muscle atrophy noted. There was diffuse tenderness to palpation of the nuchal muscles, especially on the left side from C2 to the base trapezius muscles. The trapezius muscles were also moderately tender to palpation. The upper thoracic region was quite exquisitely tender. There was dysmetria and triggering noted in both the nuchal muscles of the neck as well as the upper trapezius muscles on the left side.

Muscle testing was rated at 5/5 on the right and 4/5 on the left. Grip strength was 5/5. Negative Phalen's and negative Tinel's. No clonus. Normal sensation. Pulses 2+. ROM Cervical spine: 10 degrees of flexion and extension, 20 degrees of right rotation, 25 degrees of left rotation, 10 degrees right lateral flexion, and 15 degrees of left lateral flexion. noted that she had not reached MMI. She suggested soft tissue injections to the trigger areas in the areas of dysmetria in the cervical spine and thoracic spine as well as epidural steroid injections to the C5-C6 region. She also recommended another short course of PT.

02/06/14: The claimant underwent trigger point injections. She had four exquisite tender trigger areas, two in the nuchal area and two in the left trapezius nuchal region. All four trigger areas were injected with 2 mg of Depo-Medrol and 0.50 cc of 1% lidocaine.

02/07/14: The claimant was evaluated . She stated that the injections that she had gave her no relief. It was noted that she had done physical therapy and it did not help. She reported current pain as 8-9/10. recommended a CESI at C5-C6 in light of her C5-C6 nerve root irritation as evidenced by EMG and a neuroforaminal impingement secondary to a C5-C6 disc herniation on MRI.

02/24/14: The claimant was evaluated. A hand-written report was submitted, and the treating physician is not legible. PLAN: Cymbalta, Norco, Flexeril. CESI. The reset of the report is illegible.

03/03/14: UR. RATIONALE: I do not have a follow up note or pain diary that documents response to TP injections, which is required prior to providing another intervention in order to establish pain generator and extent of response. Criteria are not met for therapeutic injection due to absence of clinical radiculopathy C5-C6. Criteria may be met for diagnostic ESI but only if baseline/response to TPI has been established in follow up note and or with pain diary by patient. Looks like there is some evidence of L C5 radiculopathy. Still need to know response to TPI. If known and documented, L C5 diagnostic ESI with Fluoroguide would be medical reasonable.

03/19/14: UR. RATIONALE: The documentation surrounding the previous non-certification was not provided for review. The specific date and reason of the previous non-certification was not documented, and it cannot be determined whether additional information was provided for review. The request remains non-certified. The guidelines require objective evidence of radiculopathy on physical examination that is corroborated by imaging and/or electrodiagnostic testing, and unresponsiveness to conservative treatment, including exercise, physical therapy, nonsteroidal anti-inflammatory drugs, and muscle relaxants, prior to consideration of epidural steroid injection. The most recent physical examination did not document any signs of significant radiculopathy, such as motor weakness, sensory changes, or deep tendon reflex changes, corroborating the findings on electrodiagnostic testing and imaging. Documentation of failure of physical therapy and a home-based exercise program was not noted. Based on these factors, the reconsideration request for cervical translaminar epidural

steroid injection with anesthetic block and fluoroscopic guidance, to include CPT codes 62310, 77003, and 99144 is not certified.

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

The previous adverse decisions are upheld. There is no objective evidence of cervical radiculopathy suggestive of left C5 or C6 nerve distribution to correlate with the imaging and EMG. Provocative testing, such as Spurling’s maneuver, is not noted, and there is no focal sensory, motor, or reflex abnormality suggestive of that distribution. The ODG criteria for documented radiculopathy by physical examination and corroborated by imaging studies and/or electrodiagnostic testing has not been met. Therefore, the request for Cervical Translaminar Epidural Steroid Injection with Anesthetic Block and Fluoroscopic Guidance to Include CPT Codes 62310, 77003, 99144 is not medically necessary and is not certified.

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> <ol style="list-style-type: none"> (1) Radiculopathy must be documented by physical examination <u>and</u> 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. <p>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:</p> <ol style="list-style-type: none"> (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
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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**
- 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)**