

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** August 4, 2014

**IRO CASE #:**

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

Right Cervical C5-C6 ESI with Sedation

**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 Orthopaedic Surgery with over 13 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 injured her neck when she slipped on ice while working on xx/xx/xx.

01/15/14: The claimant was evaluated. The plan was to attend rehabilitative therapy for three visits per week with an expected duration of three weeks.

02/19/14: Cervical Spine MRI report. IMPRESSION: Mild cervical spondylosis resulting in mild spinal canal stenosis at C4-C5, C5-C6, and C6-C7.

03/28/14: The claimant was evaluated for neck pain and right arm pain since a work-related injury. It was noted that she went to the ER the day following the injury and was told that she had a strain. She went to physical therapy and continued to have problems. She stated that the pain was radiating into her right forearm on the radial aspect. She noted that she had some weakness but not so much numbness. She had also been treated with ibuprofen and hydrocodone. Her pain was worse at night, with sitting, walking, lying down, and with physical activity. Heat, cold, and massage made the pain better. It was noted that

physical therapy made the pain worse. On exam, reflexes were symmetric in the upper extremities. Sensation was intact. Manual motor testing revealed slight weakness of the biceps and triceps, wrist flexors, and palmar flexors on the right at 5-/5. Spurling's maneuver was positive. Hoffman's was negative. There was no clonus. She was diffusely tender along the paraspinal muscles. Pressure to the right trapezius revealed spasm. She had full range of motion but did complain of some pain in the shoulder. X-rays performed in the office on the same day showed limited flexion and extension. She had slight narrowing at the C5-C6, C6-C7, and C4-C5 levels. Assessment was neck, right shoulder, and right arm pain as well as signs of C6 and C7 radiculopathy with evidence of right-sided HNP at C5-C6, larger at C6-C7 with central protrusion, and C4-C5 was symptom precipitated by on-the-job fall in xx/xxxx. Rule out co-existent shoulder problem. EMG was recommended followed by possible transforaminal injection at either C5-C6 or C6-C7 if radiculopathy was found. She was prescribed hydrocodone, Tramadol, ibuprofen, and Flexeril.

04/15/14: The claimant was evaluated for her right shoulder pain. She was diagnosed with a possible rotator cuff tear of the right shoulder. MRI was recommended.

04/23/14: The claimant was evaluated for EMG/NCS. IMPRESSION: No conclusive electrodiagnostic evidence of a right cervical radiculopathy. There is an incidental right ulnar neuropathy at the elbow, mild.

05/02/14: The claimant was evaluated for neck, right shoulder and arm pain. On exam, she had pain with abduction as well as pain with internal and external rotation of the shoulder. She was to see for shoulder evaluation. She was given Tramadol for pain and put at light duty work. Consideration was to be given to selective nerve root block and/or facet injections depending on workup.

05/02/14: MRI of the right shoulder report. IMPRESSION: Small 4 mm articular surface partial tear at the insertion of the supraspinatus tendon on the greater tuberosity of the humerus. This involves up to 40% of the thickness of the tendon. No full-thickness tear is present. Moderate tendinosis and mild intrasubstance partial tearing in the distal 13 mm of the supraspinatus tendon. Normal labrum and bicipital tendon.

05/06/14: The claimant was evaluated whose impression was head contusion/cervical strain/cervical disc syndrome and 40% partial thickness rotator cuff tear, right shoulder. She was given a subacromial injection.

06/03/14: The claimant was evaluated. It was noted that she got absolutely no relief from the diagnostic injection that was performed on 05/06/14. He was concerned that the nerve injury (electromyographic abnormalities in the triceps on electrodiagnostic study consistent with a lower grade nerve injury) was her primary pain generator. He wanted to manage this nonsurgically.

06/16/14: The claimant was evaluated. On exam, she had right-sided tenderness about the biceps tendon with a positive speeds test. She had subjective weakness of the deltoid at 4/5. Forward flexion as well as abduction was 90 degrees and 100 degrees respectively. Sensation was intact. Spurling's was negative. Hoffman's was negative. She had no gait instability. Tinel's was mildly positive at the cubital tunnel and negative at the carpal tunnel. recommended cervical epidural steroid injection to see if she had any significant relief at the C5-C6 level on the right. If she did not get relief, he recommended considering myelogram/CT scan and then consider selective nerve root block.

06/20/14: UR. RATIONALE: The guidelines would support epidural steroid injections to determine the level of radiculopathy in cases where imaging is ambiguous or to help to determine a pain generator when physical signs and symptoms differ from those on imaging studies or to determine a pain generator when there is evidence of multi-level nerve root compression and help determine generators when clinical findings are suggestive of radiculopathy. The records do not reflect any nerve root compression on imaging. There is no documentation of any radiculopathy on the most recent physical examination. The request for C5-C6 epidural steroid injection with sedation is not certified.

07/09/14: UR. RATIONALE: This patient had a slip and fall on xx/xx/xx. She had a normal electrodiagnostic study and the cervical MRI showed mild multilevel spondylosis but no distinct nerve root entrapment. even considered her symptoms to be possibly shoulder related and she had a workup. The use of cervical ESI is equivocal as there is no validated objective radiculopathy. stated the injection would be diagnostic but has to assess C5-C6 versus C6-C7 was indistinct. An ESI will cause steroid to be dispersed beyond C5-C6. Thus, ESI not approved, but possible selective nerve block could be helpful.

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

The previous adverse decisions are upheld. The Official Disability Guidelines (ODG) support epidural steroid injections (ESI) for the treatment of cervical radiculopathy. The radiculopathy must be documented by physical examination and corroborated by imaging studies and/or diagnostic testing. 6/16/14 physical examination did not demonstrate any evidence of nerve root compression. The claimant had no sensory deficits, negative Spurling's, and negative Hoffman's. The subjective deltoid weakness was most likely related to the partial thickness tear of the rotator cuff. The cervical spine MRI demonstrated mild spondylosis with mild central stenosis at C4-C5, C5-C6, and C6-C7. There was no evidence of neuroforaminal stenosis compressing a specific nerve root. Furthermore, there was no evidence of radiculopathy on the electrodiagnostic study. Therefore, the request for Right Cervical C5-C6 ESI with Sedation does not meet ODG criteria and is not medically necessary.

ODG:

Epidural steroid injection (ESI)	<p><b>Criteria for the use of Epidural steroid injections, therapeutic:</b>  <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</i></p>
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	<p><i>treatment alone offers no significant long-term functional benefit.</i></p> <ol style="list-style-type: none"><li>(1) Radiculopathy must be documented by physical examination <u>and</u> corroborated by imaging studies and/or electrodiagnostic testing.</li><li>(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).</li><li>(3) Injections should be performed using fluoroscopy (live x-ray) for guidance</li><li>(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.</li><li>(5) No more than two nerve root levels should be injected using transforaminal blocks.</li><li>(6) No more than one interlaminar level should be injected at one session.</li><li>(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.</li><li>(8) Repeat injections should be based on continued objective documented pain and function response.</li><li>(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.</li><li>(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.</li><li>(11) Cervical and lumbar epidural steroid injection should not be performed on the same day.</li></ol> <p><b>Criteria for the use of Epidural steroid injections, diagnostic:</b></p> <p>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"><li>(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;</li><li>(2) To help to determine pain generators when there is evidence of multi-level nerve root compression;</li><li>(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;</li><li>(4) To help to identify the origin of pain in patients who have had previous spinal surgery.</li></ol>
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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)**