

Health Decisions, Inc.

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Notice of Independent Review Decision

[Date notice sent to all parties]: February 25, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Epidural Steroid Injection C7-T1 #1

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

Board Certified Anesthesiologist with over 6 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:

04-16-96: Pain Clinic Report
09-09-03: Report of Behavioral Health Assessment
02-04-04: Pain Clinic Procedure Report
03-25-04: Progress Note
05-27-04: Procedure Report
06-03-04: Progress Note
06-21-04: Intrathecal Narcotic Trial Catheter Operative Report
06-24-04: Progress Note
08-12-04: Pain Clinic Operation Report
09-23-04: Progress Note
10-21-04: Nurse Note/Office/Outpatient Visit
12-08-04: Nurse Note/Office/Outpatient Visit
01-13-05: Progress Note
02-03-05: Progress Note

03-17-05: Nurse Note/Office/Outpatient Visit
03-28-05: Progress Report
04-06-05: Pain Clinic Operation Report
06-13-05: Nurse Note/Office/Outpatient Visit
07-25-05: Progress Note
09-08-05: Nurse Note/Office/Outpatient Visit
10-10-05: Peer Review
11-03-05: Progress Note
11-21-05 thru 05-11-06: Nurse Note/Office/Outpatient Visit
06-06-06 thru 07-28-06: Office/Outpatient Visit
08-24-06: Nurse Note/Verbal Orders/Office/Outpatient Visit
11-30-06: Nurse Note/Verbal Orders/Office/Outpatient Visit
05-24-07 thru 11-16-07: Nurse Note/Verbal Orders/Office/Outpatient Visit
01-18-08 thru 04-08-08: Office/Outpatient Visit
05-09-08: Nurse Note/Verbal Orders/Office/Outpatient Visit
05-29-08: Peer Review
08-01-08: Office/Outpatient Visit
11-06-08: Nurse Note/Verbal Orders/Office/Outpatient Visit
11-18-08: Office/Outpatient Visit
11-24-08: Procedure Note
12-04-08 thru 01-29-09: Office/Outpatient Visit
02-09-09 thru 03-09-09: Office/Outpatient Visit
03-31-09: Nurse Note/Verbal Orders/Office/Outpatient Visit
04-21-09: Office/Outpatient Visit
04-29-09: CT Cervical Spine w/o contrast
06-18-09: Office/Outpatient Visit
07-05-09: Updated Peer Review
07-08-09: Nurse Note/Verbal Orders/Office/Outpatient Visit
07-08-09: Office/Outpatient Visit
07-22-09 thru 08-05-09: Office/Outpatient Visit
10-12-09: Nurse Note/Verbal Orders/Office/Outpatient Visit
10-13-09: Independent/Required Medical Examination
11-23-09 thru 12-30-09: Office/Outpatient Visit
01-14-10: Nurse Note/Verbal Orders/Office/Outpatient Visit
03-10-10 thru 10-30-10: Office/Outpatient Visit
04-13-10 thru 07-06-10: Nurse Note/Verbal Orders/Office/Outpatient Visit
08-17-10: ED Record
09-02-10: Office/Outpatient Visit
10-07-10: Nurse Note/Verbal Orders/Office/Outpatient Visit Office/Outpatient Visit
and Procedure Note, Admission Note
10-08-10: Progress Note
10-08-10: Pathology Report
10-09-10: Discharge Note
10-12-10: Procedure Note
10-14-10: Peer Review
10-19-10 thru 11-08-10: Office/Outpatient Visit
01-06-11: Nurse Note/Verbal Orders/Office/Outpatient Visit
03-01-11: Office/Outpatient Visit

04-04-11: Report of Behavioral Health Assessment
04-07-11: Nurse Note/Verbal Orders/Office/Outpatient Visit
07-06-11: Procedure Note
08-11-11: Nurse Note/Verbal Orders/Office/Outpatient Visit by RN
08-11-11: Procedure Note
09-08-11 thru 10-18-11: Office/Outpatient Visit
10-24-11: Peer Review
10-25-11: Peer Review
11-29-11 thru 02-28-12: Nurse Note/Verbal Orders/Office/Outpatient Visit
04-24-12: Office/Outpatient Visit
05-24-12: Required Medical Examination
06-14-12: EMG Report
06-26-12: Nurse Note/Verbal Orders/Office/Outpatient Visit
08-29-12: Office/Outpatient Visit
09-25-12: Nurse Note/Verbal Orders/Office/Outpatient Visit
11-01-12: Office/Outpatient Visit
11-30-12: Examination Notes
12-18-12: Nurse Note/Verbal Orders/Office/Outpatient Visit
12-21-12 thru 12-28-12: Office Visit
02-07-13 thru 03-05-13: Office/Outpatient Visit
03-08-13: Examination Notes
03-15-13 thru 04-03-13: Office Visit
03-19-13: Nurse Note/Verbal Orders/Office/Outpatient Visit
04-08-13 thru 05-13-13: Office/Outpatient Visit
07-02-13: Nurse Note/Verbal Orders/Office/Outpatient Visit
09-04-13: Required Medical Examination
10-03-13: Office/Outpatient Visit
10-16-13: Nurse Note/Verbal Orders/Office/Outpatient Visit
11-15-13: CT Cervical Spine w/o IV Contrast interpreted
11-28-13: Office/Outpatient Visit
12-09-13: URA
01-16-14: Nurse Note/Verbal Orders/Office/Outpatient Visit
01-20-14: URA

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male that reported on xx/xx/xx. He reports popping and tingling through his neck and back. The claimant has tried ESI's, PT, ACDF C3-6, posterior cervical fusion C4-6, dorsal column stimulator, trigger point injections and Intrathecal narcotics catheter for continuous infusion without more than 50% relief.

04-16-96: Pain Clinic Report. The claimant presents with diagnosis of levator scapula syndrome. He has severe myofascial pain involving the right shoulder region with associated headaches. Procedure: Ten trigger points involving the trapezius, levator scapula and spinatus musculature.

02-04-04: Pain Clinic Procedure Report. Preoperative Diagnosis: Post laminectomy syndrome cervical spine. Suboccipital headaches secondary to #1. Procedures Performed: 1. Placement of two dorsal column stimulator leads in a subcutaneous fashion for C2 nerve root stimulation. 2. Fluoroscopy for guidance and interpretation.

05-27-04: Procedure Note. Preoperative Diagnosis: 1. Postlaminectomy syndrome of the cervical spine. 2. Postlaminectomy syndrome of the lumbar spine. Procedure Performed: Intrathecal narcotic injection – single shot.

06-03-04: Progress Note. The claimant presents today for evaluation and treatment. He had a single shot Intrathecal narcotic trial of which he got 100% pain relief for 24 hours. My recommendation is to schedule him for an Intrathecal narcotic trial.

06-21-04: Intrathecal Narcotic Trial Catheter Operative Report. Preoperative Diagnosis: 1. Postlaminectomy syndrome of the cervical spine. 2. Postlaminectomy syndrome of the lumbar spine. Procedure Performed: Placement of Intrathecal trial catheter for continuous infusion.

06-24-04: Progress Note. The claimant presents today for evaluation and treatment. His Intrathecal narcotic catheter, which was removed today, gave him 100% pain relief. Current plan is to schedule him for permanent pump placement.

08-12-04: Pain Clinic Operation Report. Preoperative Diagnosis: 1. Postlaminectomy syndrome of the cervical spine. 2. Postlaminectomy syndrome of the lumbar spine. Procedure Performed: Permanent implantation of a permanent Intrathecal narcotic catheter for continuous infusion.

09-23-04: Progress Note. The claimant presents today for evaluation and treatment. He has an Intrathecal pump and is overall 60% better. Dosage increased from 1.2mg/day to 1.5mg/day.

04-06-05: Pain Clinic Operation Report. Preoperative Diagnosis: 1. 1. Postlaminectomy syndrome of the cervical spine. 2. Myofascial Pain Syndrome. Procedure Performed: 1. Cervical Epidural Steroid Injection. 2. Myofascial Trigger Point Injection times four.

10-10-05: Peer Review. The claimant was injured and had neck with Lhermittes. He reported right index finger was going to sleep. The claimant had normal motor and sensory exam and reflexes. The claimant had an MRI on 11-25-89 (prior to injury) that showed mild degeneration at C4-5 with mild to moderate degeneration at C5-6 with moderate congenital stenosis at this level. The claimant was in an MVA in 1985 and sustained a sagittal fracture of C5, treated with halo. He had studies done in 1990 for a symptomatic flare up and he noted the symptoms gradually resolved. MRI of cervical spine dated 06-08-91 showed no appreciable changes. The claimant was seen on 06-17-91 was neurologically intact and diagnosis was cervical strain and he may be symptomatic from degenerative discs

adjacent to his old fracture. The claimant then had ESI's and PT with no improvement. On 10-30-91 he was diagnosed with compression fracture of C5 with degenerative changes in discs above at C4-5 and below at C5-6 and surgery was recommended. On 01-22-92 the claimant had ACDF C3-6 performed. After which the claimant was no longer experiencing headaches and required only occasional pain medication. He was neurologically intact in the low back and had full motion. Diagnosis was strain of lumbar musculature. On 03-12-93 the claimant had repeat f/e x-rays that showed C3-4 was definitely solid and C5-6 had at least a fibrous union if not solid fusion. In extension there was motion across C4-5, which was a definite pseudoarthrosis. The claimant was seen on 12-09-93 presenting with persistent lumbar discomfort with intermittent leg sx, suggestive of radiculopathy. On 11-29-95 a posterior cervical fusion C4-6 was performed. MRI of the cervical spine on 07-09-97 showed fusion from C4 to C6. There was small, linear focus of increased signal intensity in ventral aspect of spinal cord at C5-6. The length and frequency of treatment has been excessive, including the injections, implants and surgeries.

06-06-06: Office/Outpatient Visit. The claimant presents with bilateral neck pain that radiates to the left temple, posterior neck, posterior skull bilateral and left and right subscapular region. Assessment: Postlaminectomy syndrome, cervical region. Plan: Follow up only as needed.

07-07-06: Office/Outpatient Visit. The claimant is having his pump decrease on a regular basis (on 07-28-06 only decrease documented) with no change in pain. Pump dosage increases on 04-08-08, 08-01-08, 12-04-08, 11-23-09 and 09-02-10. The claimant at this time is positive for arthralgias and neck pain and headaches.

11-18-08: Office/Outpatient Visit. The claimant presents for follow up on his cervical disc disease. Plan: The battery in the Intrathecal implanted pump has expired. This needs to be replaced on an emergent basis. The claimant is in morphine withdrawal and having increased severe pain.

11-24-08: Procedure Note. Procedure: 1. Removal of Medtronic programmable pump from the left hip pocket. 2. Replace with new Medtronic pump.

04-29-09: CT Cervical Spine w/o contrast. Impression: 1. Noncontrast CT examination of the cervical spine only. Patient has iodine allergy. 2. Status post fusion C3-C6 without evidence of complication. 3. Superior neurostimulator lead at level of superior C3. 4. Mild anterolisthesis of C2 on C3 with mild left neuroforaminal narrowing.

07-08-09: Office/Outpatient Visit. Procedures: Cervical ESI and trigger point injections x 3 or more muscle groups. Assessment: Reflex sympathetic dystrophy of lower limb (Achilles tendon rupture), Postlaminectomy syndrome, cervical region and myofascial pain syndrome.

07-22-09: Office/Outpatient Visit. The claimant presents with the following current problems: Low back pain, Myofascial pain syndrome, Postlaminectomy syndrome – cervical and lumbar region, Reflex sympathetic dystrophy of lower limb. Procedures: ESI, Trigger point injections x 3 or more muscle groups.

08-05-09: Office/Outpatient Visit. Procedures: ESI, Trigger point injections x 3 or more muscle groups.

10-07-10: Office/Outpatient Visit. The claimant presents with open wound at battery site. Visible dermis with a hole, or crater in the center of the wound. In the center of the crater, there is a pinpoint area of silver metal visible. The area is red and draining. Plan: Stimulator battery must be removed emergently. The claimant will be admitted as an inpatient and put on IV antibiotics until the infection is resolved.

10-07-10: Procedure Note. Procedure: 1. Removal of the dorsal column stimulator battery in the left hip pocket. 2. Removal of connecting cables. 3. Removal of the dorsal column stimulator leads.

10-09-10: Discharge Note. The claimant has been in the hospital for 2 days and receiving IV Vancomycin and daily wound change.

10-12-10: Procedure Note. Procedure: Delayed primary closure of 3 wounds with the top 2 wounds being 2cm each and the bottom wound being approximately 7cm.

07-06-11: Procedure Note. Procedure: Placement of 2 octad electrodes in the subcutaneous tissue for peripheral nerve stimulation.

08-11-11: Procedure Note. Procedure: Placement of 4 octrode leads in the subcutaneous space for peripheral nerve stimulation.

09-08-11: Office/Outpatient Visit. The claimant presents for follow up wound check. His wound is closed with no drainage. His pain seems worse in the daytime, however, reports 40-50% relief with stimulator.

10-08-11: Office/Outpatient Visit. The claimant presents for follow up after dorsal column stimulator has been adjusted. He is receiving good coverage and pain is primarily in bilateral neck in the cervical spine.

04-24-12: Office/Outpatient Visit. The claimant presents with bilateral neck pain that does not radiate. His pain has overall improved since first visit and worse since last visit. He reports tingling in the right arm after he has been sleeping on this side. Procedure: Analysis of pump with reprogramming. Assessment: Postlaminectomy syndrome, cervical region. Paresthesia right arm. Plan: Nerve conduction studies of the right arm.

06-14-12: EMG Report. 1. The above electrodiagnostic study reveals evidence of a mild ulnar neuropathy bilaterally affecting sensory components. 2. There is no electrodiagnostic evidence of a cervical radiculopathy.

08-23-12: Office/Outpatient Visit. The claimant presents with bilateral neck pain radiating to bilateral shoulders, left and right subscapular region, and bilateral arm numbness. He notes some pain relief with applying ice, use of cervical stimulator, Intrathecal pump and oral medications.

11-01-12: Office/Outpatient Visit. The claimant presents with bilateral neck pain that radiates to the bilateral shoulders, left and right subscapular region, arms, with left arm pain greater than the right and bilateral arm numbness. The claimant states stimulator helps cervical pain but not shoulder pain. Plan: Recommend physical therapy.

11-30-12: Examination Notes. The claimant presents with mid back pain. This has persisted for 2 months and is in the upper mid-back area between his shoulder blades. He states pain is 6/10. Inspection: Right shoulder high and cervical hypolordosis. Shoulder ROM WNL bilaterally. On palpation, fixation noted in the thoracic region at T4, T5, T6, muscle spasm noted in the thoracic region. Schepelmann's sign positive with pain. Pain sensation testing: Cervical: left and right: hyperalgesia. Prognosis/Diagnosis: The likelihood of complete symptomatic relief within 4 weeks is excellent. The patient should reach maximum medical improvement. The patient's prognosis is good. Diagnosis: Thoracic segmental dysfunction. Thoracic rib segmental dysfunction. Deep and superficial muscle spasms. Thoracalgia.

12-21-12: Office Visit. The claimant states he has experienced 40% improvement.

03-08-13: Examination Notes. The claimant presents with bilateral lower cervical and upper mid-back area between the shoulder blades pain measured 7/10. On inspection his right shoulder is high and there is cervical hypolordosis. Cervical ROM is restricted with pain. On palpation there is tenderness and muscle spasm noted in the thoracic and cervical region. There is bilateral hyperalgesia in the cervical and thoracic region.

04-08-13: Office/Outpatient Visit. The claimant presents with constant, dull and stabbing pain primarily in the bilateral neck and posterior thoracic area. And radiates to the left and right subscapular region. He was last prescribed a Medrol dose pak, Skelaxin and increased his ITP with no changes to pain. There is myofascial tenderness in bilateral cervical paraspinalis, trapezius, levator scapulae, worse on the left. Straight leg raise was negative. Normal reflexes and sensation in all areas. Trigger pint injection to the bilateral trapezius and levator scapulae region were recommended.

10-03-13: Office/Outpatient Visit. The claimant presents with increased pain. He notes some temporary pain relief with ice, medication, and dorsal column

stimulator. The stimulator was on high setting and he reported 50% overall relief to his cervical region with it. Narcotic medications include Norco, Morphine, Bupivacaine and Clonidine. At CT scan of the cervical spine was recommended.

10-16-13: Nurse Note/Verbal Orders/Office/Outpatient Visit. The claimant presents with pain that is constant, burning, dull, sharp, shooting and stabbing with intermittent numbness/tingling to arms. The location of his pain is primarily bilateral neck that radiates to the upper thoracic spine, bilateral shoulders, and bilateral scapular region. VAS scoring is 7/10. Neurological examination was positive for paresthesia (bilateral upper extremity) and negative for weakness. Procedures: CPM Infusion Therapy Services. Services Requested: Intrathecal pump refill with telemetry.

11-15-13: CT Cervical Spine w/o IV Contrast. Impression: 1. Anterior and posterior cervical fusions from C3-C6. The fusion appears well-healed and the alignment is unchanged. 2. Mild degenerative disc disease at C2-3 with slight narrowing of the intervertebral foramen of the left side. 3. Prominent degenerative disc disease at C6-C7 with narrowing of the intervertebral foramen on the right side. This has progressed since the examination 4 years previous. 4. Removal of previous extradural stimulators. 5. Subcutaneous stimulator is now in place.

11-28-13: Office/Outpatient Visit. After review of the CT scan it was recommended to proceed with a Cervical ESI in hopes to calm current pain. The claimant was advised if no relief is gained, they would discuss possible peripheral nerve stimulator trial.

12-09-13: URA. Rationale for Denial: Based on the clinical information provided, the request for cervical epidural steroid injection C7-T1 #1 is not recommended as medically necessary, RME dated 09/23/13 indicates that treatment to date includes work condition, work hardening, physical therapy, psychological therapy, pain management, e-stim, massage, trigger pint injections, epidural steroids, facet injections and nerve root blocks. The patient has had two cervical laminectomies and fusions which did not help significantly. The patient has a spinal cord stimulator and intrathecal morphine pump which allow him to work full duty with no restrictions. Cervical CT dated 11/15/13 revealed at C7-T1 a generalized disc bulge is noted. No definite disc herniations are demonstrated. The disc bulge indents the thecal sac but does not compress the spinal cord. There is no narrowing of the interveterbral foramina. There is no current, detailed physical examination submitted for review to establish the presence of active radiculopathy, and the submitted MRI does not document any significant neurocompressive pathology. Therefore, the request for cervical epidural steroid injection is non-certified.

01-20-14: URA. Rationale for Denial: The documentation submitted for review elaborates the patient complaining of neck pain despite a previous surgical procedure. The Official Disability Guidelines recommends an epidural steroid injection in the cervical region provided the patient meets specific criteria to include imaging studies confirming the patient's neurocompressive findings. No

significant pathology was confirmed by the submitted MRI, specifically at the C7-T1 level. Given this, the request does not meet guideline recommendations.

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

The previous adverse determinations are upheld. Claimant has had two cervical laminectomies and fusions that have not helped significantly. Additionally, claimant has a spinal cord stimulator and intrathecal morphine pump which allow him to work full duty without restrictions. Cervical CT on 11/15/13 showed a generalized disc bulge at C7-T1, without definite disc herniations. There is no compression of the spinal cord or narrowing of the intervertebral foramina. Physical examination does not demonstrate active radiculopathy. Furthermore, MRI does not show any neurocompressive pathology. Per ODG, without demonstrated radiculopathy this request for Cervical Epidural Steroid Injection C7-T1 #1 is non-certified.

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)**