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Notice of Independent Review Decision

Date notice sent to all parties:

August 19, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical ESI 62310

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

Board Certified Orthopedic Surgeon (Joint)

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped and hurt his back and neck. Designated doctor evaluation dated 12/14/13 indicates that the patient was treated with physical therapy and epidural steroid injections x 3, with the most recent injection in October which gave him some relief. Anticipated MMI date is 03/08/14. Post designated doctor evaluation dated 03/19/14 indicates that diagnoses are contusion to the back, age-related degenerative changes in the lower back, no evidence of radiculopathy, and symptom exaggeration. He has no objective findings of radiculopathy. The patient was determined to have reached maximum medical improvement with 5% whole person impairment. Cervical MRI dated 05/01/14 revealed no areas of disc

herniation, facet arthropathy or ligamentum flavum hypertrophy producing central canal or neural foraminal stenosis at C2-3. At C3-4 there is a central annular tear. There are no areas of disc herniation or ligamentum flavum hypertrophy producing central canal stenosis or neural foraminal stenosis. At C4-5 there are no areas of disc herniation, facet arthropathy or ligamentum flavum hypertrophy producing central canal or neural foraminal stenosis. At C5-6 there is a broad based central disc protrusion (herniation) measuring 3.5 mm producing mild central canal stenosis and moderate stenosis of the bilateral lateral recesses touching the bilateral C6 nerve roots. At C6-7 there is a broad based central/left paracentral disc protrusion (herniation) measuring 3 mm producing mild central canal stenosis and mild stenosis of the left lateral recess. Orthopedic consultation dated 05/16/14 indicates that Spurling is positive on the left. Motor strength was weakened in wrist flexion and extension as well as in shoulder abduction. Designated doctor evaluation dated 05/21/14 indicates that strength is 5/5 in the upper extremities. Deep tendon reflexes are 2+ bilaterally. Diagnosis is cervical sprain/strain. The patient has reached MMI as of 05/21/14 with 5% whole person impairment. Orthopedic report dated 06/20/14 indicates that neck pain is rated as 6/10. The level to be injected is left C6.

Initial request for cervical epidural steroid injection was non-certified on 06/11/14 noting that the request is nonspecific and does not indicate the level to be injected. The patient was recently enrolled in a chronic pain management program; however, the patient's response to this tertiary level program is not documented. The denial was upheld on appeal dated 07/09/14 noting that the request as submitted fails to indicate the level that was to be injected. While a left C6 epidural steroid injection would be supported, without a successful peer to peer discussion to modify the request, the request in its entirety is non-certified.

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 cervical epidural steroid injection 62310 is not recommended as medically necessary. Both previous denials have indicated that the request, as submitted, is nonspecific and does not identify the level and laterality to be injected. The submitted records indicate that the patient will be injected at the left C6 level. However, the request continues to be submitted without a level or laterality. Additionally, there is no information provided regarding the chronic pain management program mentioned in the initial denial. Admission to a chronic pain management program denotes a finding of exhaustion of lower levels of care. Given the current clinical data, 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 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 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) The FDA is warning that injection of corticosteroids into the epidural space of the spine may result in rare but serious adverse events, including loss of vision, stroke, paralysis, and death. (FDA, 2014) 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.