AccuReview

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Notice of Independent Review Decision

[Date notice sent to all parties]: July 15, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical ESI C6-7 Left

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

This physician is board certified in Orthopaedic Surgery with over 14 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 xx-year-old who was injured on xx/xx/xx. The mechanism was a motor vehicle accident. The diagnosis was cervicalgia. Since the injury, the claimant had been treated with PT, medication management, and activity restrictions.

03-31-15: MRI Cervical w/o Contrast. Impression: 1. There is a right central to foraminal disc protrusion at C4/5 with contact of the right surface of the cord with slight indention. There is moderate right neuroforaminal narrowing at this level with exiting nerve contact. Correlate with patient's symptomatology. 2. Mild discogenic change at C6/7.

05-12-15: Neurosurgery Office Visit: neck pain. Claimant complained of neck pain that radiates to bilateral upper extremities (more to left) with a burning sensation, described as aching; pain 5/10. The claimant complained of numbness to the upper extremities (more to the left) and weakness in the upper extremities (more to left) as well as neck stiffness. Claimant has completed 8/10 PT sessions in the last year with good relief. Medications: Carbidopa-levodopa, chlorzoxazone, lisinopril, naproxen, testosterone, Toviaz, Tylenol with Codiene #4, Vitamin B12, Vitamin B6, Vitamin C, Vitamin E. ROS: Musculoskeletal: positive for myalgias, positive for neck pain, positive for back pain. Neurological: positive for headache, positive for numbness, positive for weakness.

05-21-15: UR. Reason for denial: The requested left-sided C6-7 cervical epidural injection cannot be recommended as medically necessary. This claimant does not have focal radicular complaints and does not have significant

neurocompressive pathology on the left at the C6-7 level. Therefore, the claimant does not meet criteria for epidural steroid injection based on the information reviewed and discussed.

06-03-15: Neurosurgery Office Visit. CC: neck pain. ROS: Neurological: positive for numbness, positive for weakness. Musculoskeletal: positive for neck pain. PE: Musculoskeletal: positive spurling on the right. Impression: Neck pain with radiculopathy. Failure to improve after 20 sessions of PT. Herniated disc at C4-5. Plan: Resubmitting for ESI at the C6-7 level on the right hand side, consistent with his complaints today.

06-16-15: UR. Reason for denial: The ODG regarding ESI states "Not recommended based on recent evidence, given the serious risks of this procedure in the cervical region , and the lack of quality evidence for sustained benefit." For this reason, the request is not supported. Therefore, this request is met with an adverse determination.

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

The previous adverse determinations are upheld and agreed upon. The claimant does not require an epidural steroid injection (ESI) at C6-7, based on the records reviewed. The Official Disability Guidelines (ODG) support an ESI for the patient with radiculopathy associated with a herniated nucleus pulposus in the cervical spine. Objective findings should correlate with imaging studies and/or electrodiagnostic testing. According to the June 2015 office note, the claimant has numbness and weakness in the upper extremities. The claimant's cervical spine MRI demonstrated disc protrusions at C4-5 and C6-7. The study revealed moderate right-sided foraminal stenosis at C4-5 and mild foraminal stenosis at C6-7. The claimant has failed conservative treatment with physical therapy and medication. The claimant's examination is not consistent with compression a specific nerve root due to a herniated disc. It is unclear whether the treating physician is targeting pathology at C4-5 or C6-7. Electrodiagnostic testing is recommended to identify the pain generator in this patient prior to consideration of a cervical ESI. Therefore, after reviewing the medical records and documentation provided, the request for Cervical ESI C6-7 Left does not meet criteria and is non-certified.

Per ODG:

Epidural steroid injections (ESIs), therapeutic	**Criteria for the use of Epidural steroid injections:** *Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.* (1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, muscle relaxants & neuropathic drugs). (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. (4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be 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) *Therapeutic phase:* If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks,

	additional blocks may be supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007) (8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. (9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment. (10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar 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. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

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)**