

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: December 6, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

ESI Cervical with sedation

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 female whom was injured while working on xx/xx/xx. Claimant stated that she was walking, as she went to open the door slipped on a wet spot, she fell still holding on to the door knob with her right hand. Claimant felt pain in right shoulder, neck, and back.

09-03-14: MRI Cervical Spine dictated. Impression: 1. No compression fracture or spondylolisthesis. 2. Straightening of the normal lordosis of the cervical spine, nonspecific, but under the clinical setting of neck pain, can be related to muscle spasm. 3. Diffuse disc dehydration with multilevel annular and disc bulges, with associated central canal narrowing at C6-7 and C7-T1 without cord compression or cord signal abnormality.

09-26-14: Status Report: Follow-up Evaluation. Subjective Complaints: Claimant stated she had some increased pain in back from therapy this morning;

felt that she has improved somewhat and therefore would like to stop therapy. Pain 1/10. Cervical Spine: Overall symptoms have remained the same and ROM has returned to normal; radiating pain has resolved with no numbness and/or tingling. Claimant has a right shoulder complaint. PE: Cervical Spine: Muscle spasm along the paraspinal muscle resolved. Spurling's test is negative. X-Rays: negative. Special Testing: 09/05/14 MRI on Bilateral Cervical Spine without contrast and Right shoulder without contrast: MRI right shoulder done 9/3/14 revealed narrowing of acromiohumeral distance which can predispose to impingement with supraspinatus tendinosis with subacrominal and subdeltoid fluid indicative of bursitis. MRI C-Spine done 9/3/14 revealed diffuse disc dehydration and bulges at multilevel with associated central canal narrowing at C6-7 and C7-T1 without cord compression and signs of muscle spasms. 09/26/14-Ortho for Right Shoulder: Seen 9/23/14 and advised doing well. Advised probably had a mild neurologic injury and advised observation for now. F/U 10/21/14 or PRN. 09/26/14-ESI: Claimant stated neck feels fine right now and wishes to cancel spine referral. Diagnosis: Bilateral sprain of neck 847.00, Bilateral sprain of thoracic 847.10, Bilateral sprain of lumbar 847.20, Right sprain shoulder/arm NEC-sprains and strains of other specified sites of shoulder and upper arm 840.80, Right shoulder region-Other specified disorders of joint 719.81, Tripping-fall from other slipping E885.9. Recommendations: No physical therapy at this time, take OTC medications as needed, trial of full duty, seen 9/23/14 and advised doing well, advised probably had a mild neurologic injury and advised observation for now, F/U 10/21/14 or PRN, claimant stated neck feels fine right now and wishes to cancel spine referral, F/U in 1 week.

10-15-14: Status Report: Follow-up Evaluation. Subjective Complaints: Claimant stated she is still having the pain in her neck, burning sensation in neck with numbness and tingling in left leg (from upper thigh to knee) with pain 2-3/10 and burning sensation between her shoulder blades. Cervical Spine: Overall symptoms have increased with pain 3/10. PE: Cervical Spine: side bending decreased, extension decreased, tenderness to palpation has increased. Diagnosis: Bilateral sprain of neck 847.00, Bilateral sprain of thoracic 847.10, Bilateral sprain of lumbar 847.20, Right sprain shoulder/arm NEC-sprains and strains of other specified sites of shoulder and upper arm 840.80, Right shoulder region-Other specified disorders of joint 719.81, Tripping-fall from other slipping E885.9. Recommendations: no physical therapy at this time, medications: Naprosyn 500mg, Flexeril 10mg, continue full duty, med refills given, will refer to spine for failure to progress, F/U in 1 week, Referral to the Spine.

10-30-14: Office Visit. CC: neck pain. Complained of pain worse at night, pain awakens from sleep. Medications: BRP-3 apply 3-4 times a day, Zanaflex 2mg PO BID. PE: Claimant is sitting uncomfortably and gait is antalgic to the left. Upper extremities strength is symmetrically present in all upper extremity muscle groups. Upper extremities reflexes are symmetrically present and normal. Light touch is normal for all cervical dermatomes. Assessment: 5/5 strength in bilateral upper and lower extremities, no hyperreflexia and no clonus and no assistive aids. Plan: Cervical spondylosis without myelopathy, C6-7 disc herniation, cervical radicular syndrome. ESI cervical, topical, Zanaflex 2mg tablets, continue

conservative care, no myelopathy, neurologically intact. New medications: BRP-3 apply 3-4 times a day, Zanaflex 2mg PO BID. Problems added: cervical Radicular Syndrome 723.4, Cervical Spondylosis without Myelopathy 721.0. Orders: 1. C-spine; AP/Flex/Ext 72040, 2. ESI (CPT-ESI) w/steroid at cervical.

11-10-14: UR. Reason for denial: The claimant is not described as having any radicular upper extremity pain or symptoms i.e. the presence of objective neurological deficits such as myotomal muscular weakness, reflex change or pain or sensory depression in a dermatomal pattern. A positive Spurling's is not described. There is no description of definite imaging study evidence of a neurocompressive lesion that might be expected to respond to ESI's. Guidelines state that "radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing." Without the presence of true radicular symptoms or signs as described above or definite imaging study evidence of a neurocompressive lesion, guidelines would not support proceeding with treatment with ESI's,

11-18-14: UR. Reason for denial: A previous review for this request was performed on 11/10/14. The request was denied as the claimant was not described as having any radicular upper extremity pain or symptoms. A positive Spurling's was not described and there was no description of definite imaging study evidence of a neurocompressive lesion that might be expected to respond to ESI's, ODG-TWC notes criteria for the use of epidural steroid injections including documented radiculopathy by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, and initially unresponsive to conservative treatment. Exam findings note that strength, sensation, and reflexes are symmetrical and within normal limits. In this case, there is limited objective evidence suggestive of radiculopathy. Based on the submitted clinical findings, documentation, and evidence based guidelines, the medical necessity of this request is not established. Recommend non certification.

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

Previous adverse determinations are upheld and agreed upon. The claimant is not indicated for an epidural steroid injection (ESI) in the cervical spine. The Official Disability Guidelines (ODG) supports ESI in the setting of radiculopathy due to a herniated nucleus pulposus. The radiculopathy should be confirmed by imaging studies and/or electrodiagnostic testing. The claimant currently complains of neck pain without upper extremity radicular symptoms. She has no objective evidence of cervical radiculopathy on examination. The claimant's MRI demonstrates no evidence of significant neural foraminal narrowing associated with a disc herniation. The claimant does not meet criteria for ESI. Therefore, after review of medical records and documentation received, the request for ESI Cervical with sedation is denied.

Per ODG:

<p>Epidural steroid injections (ESIs), therapeutic</p>	<p>Criteria for the use of Epidural steroid injections:</p> <p><i>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.</i></p> <p>(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.</p> <p>(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).</p> <p>(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.</p> <p>(4) <i>Diagnostic Phase:</i> 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.</p> <p>(5) No more than two nerve root levels should be injected using transforaminal blocks.</p> <p>(6) No more than one interlaminar level should be injected at one session.</p> <p>(7) <i>Therapeutic phase:</i> 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)</p> <p>(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.</p> <p>(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.</p> <p>(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.</p> <p>(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.)</p>
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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)**