



Specialty Independent Review Organization

DATE OF REVIEW: 7/30/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under dispute include a cervical Epidural Steroid Injection at C6/7 with fluoroscopy.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation with greater than 10 years of experience.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

The reviewer disagrees with the previous adverse determination regarding all services under review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the treating doctor, patient and from the URA. Records include the following: DWC intake forms, denial letters 6/14 through 6/28/07, Notes by Dr. of 5/11/00 through 6/20/07, 8/26/99 to 7/21/05 radiographic reports, 1/23/03 cervical ESI report and 4/9/99 through 1/23/02 operative reports.

PATIENT CLINICAL HISTORY [SUMMARY]:

This person was injured on xx/xx/xx when he was involved in a motor vehicle accident. He underwent ACDIF from C4-C6 with instrumentation in October of 1994. On 1/23/02, he underwent removal of the anterior plate of C4-C6, ACDIF at C6/7 and fusion at this level when he developed C7 radicular symptoms in the interim. He has also undergone lumbar surgery. The note of 2/13/06 indicates that he underwent a cervical ESI from which he responded well enough to reduce his needs for pain medications and increase his functionality.

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

As per the current DWC rules, the ODG is mandated for this review process. In reference to 723.4 cervical radiculopathy, these guidelines indicate it is “recommended as an option for treatment of radicular pain as per the following criteria. **Criteria for the use of Epidural steroid injections:** Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and 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 and corroborated by imaging studies and/or electrodiagnostic testing. **In this case the treating doctor has requested imaging studies (i.e. CT myelogram for corroboration) however, these studies have been denied.**
- 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. **In this case the fluoroscopic guidance is requested.**
- 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. **In this case, the ESI is being used for analgesic/therapeutic purposes until work up can be authorized or obtained.**
- 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. **In this case one level (C6/7) is being requested.**
- 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. **As per the documentation provided, the request for ESI is well within the established frequency recommendations.**
- 8) Repeat injections should be based on continued objective documented pain and function response. **Documentation of a positive response to ESI is made on 2/13/06, “responded reasonably well but he did not get total pain relief, but certainly enough to reduce his medications and make him more functional...”**
- 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. **The reviewer indicates that this portion of the criteria is inconsistent with criteria number 7.**

This patient has a left sided cervical radiculopathy which has previously responded to ESI treatment and the ODG recommends said treatment; therefore, the care is medically reasonable and necessary.

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)