DATE OF REVIEW: 03/07/07 (AMENDED 03/14/07)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

01992 Anesthetic nerve block associated with C5-C6 epidural steroid injection

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

Board Certified
Fellowship Trained in Pain Medicine
Added Qualifications in Pain Medicine

REVIEW OUTCOME

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

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An evaluation with an unknown provider (no name or signature was available) dated xx/xx/xx
An evaluation with, R.N., M.S.N. dated 08/21/06
An evaluation with, M.D. dated 09/18/06
An evaluation with, R.N. for Dr. dated 10/16/06
A letter from, Utilization Review Nurse, dated 10/25/06
An evaluation with an unknown provider (no name or signature was available) dated 11/01/06
An operative note from Dr. dated 11/09/06

Explanation of Benefits forms from dated 12/20/06 and 01/31/07
A letter of dispute from, R.N. at dated 02/20/07
An undated report regarding monitored anesthesia care

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, Ms. recommended increased Methadone. On 09/18/06, Dr. recommended continued Dolophine, Cymbalta, Lyrica, and Senokot. On 10/16/06, Ms. recommended a cervical epidural steroid injection (ESI) and Dolophine, Lortab, Zanaflex, and Cymbalta. Ms. wrote a letter of medical necessity for the ESI on 10/25/06. Another unknown provider also recommended an ESI on 11/01/06. Dr. performed the cervical ESI on 11/09/06. On 12/20/06 and 01/31/07, wrote letters stating they did not support the medical necessity for IV sedation or general anesthesia during a nerve block. On 02/20/07, Ms. wrote a letter denying additional payment for monitored anesthesia care.

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

This patient had no physical examination evidence of radiculopathy, no objective evidence of radiculopathy, and no radiological imaging study demonstrating disc herniation, spinal stenosis, foraminal stenosis, spinal cord impingement, or nerve root impingement. Epidural steroid injections are indicated for treatment of disc herniation with neural compromise causing radiculopathy. In this case, that condition was clearly not present. Furthermore, the CPT code 01992 for generalized anesthesia or IV sedation would not be reasonable or necessary during the performance of an ESI. Moreover, according to Dr. operative note, the medications injected into this patient's epidural space were not medically reasonable or necessary, were not FDA approved for use in the epidural space, and are not supported by standard of care for medical literature (specifically Toradol, Norflex, and Baclofen). Therefore, absent appropriate medical indications for this procedure, as well as use of appropriate medications for administration in the epidural space, there was no medical indication, reason, or necessity for cervical epidural steroid injection as related to the patient's original injury.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X 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
- [x] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- [ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- [ ] MILLIMAN CARE GUIDELINES
- [x] 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)