

True Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW:

NOVEMBER 18, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical epidural steroid injection and cervical CT

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

No ODG Guidelines
Peer review, 09/20/07 and 10/04/07
Cervical spine MRI, 05/17/07
Office notes, Dr., 09/13/07, 09/24/07 and 10/18/07
Letter of appeal, Dr., 10/03/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx year old female had the onset of neck and right arm pain on xx/xx/xx when she was typing. A 05/17/07 MRI of the cervical spine showed mild left neural foraminal narrowing at C4-5. C5-6 and C6-7 demonstrated a 2 millimeter central disc protrusion with mild central canal stenosis and mild bilateral neural foraminal narrowing. Dr. evaluated the claimant on 09/13/07 for neck pain, right trapezial pain and right scapular pain that radiated down the right arm with intermittent numbness and tingling. Motor, sensory and strength were intact. Hoffmann's was present bilaterally. The impression was right cervical radiculopathy with myelopathy and C5-6 disc protrusion versus spondylosis. The physician recommended a CT scan as some images on the MRI were

degraded. He also recommended epidural steroid injections. The epidural steroid injection was denied on peer review and the CT scan was approved.

On 10/18/07 Dr. documented exam findings of positive Hoffmann's reflex and positive brachioradialis reflex. Right wrist extension was 5-/5. He noted that the CT scan was done on 10/10/07 and showed a diffuse C5-6 disc protrusion with a right sided C5-6 paramedian spur causing right C5-6 lateral recess stenosis. There was a small central spur at C6-7. A cervical epidural steroid injection was again requested.

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

The claimant is a xx-year-old woman with neck and radicular arm complaints following a xx/xx/xx injury. The review indicates a 05/17/07 MRI of the cervical spine that documents disc bulging at a couple of levels. There are then office visits from Dr. documenting physical findings of spasm, positive Hoffman's sign and lack of improvement with conservative care. The Reviewer has reviewed a 10/04/07 peer review that indicates that the epidural steroid injections were not indicated but the CT scan was indicated since the MRI views were degraded and CT scan was needed to better evaluate the underlying pathology. There is also a 10/18/07 office visit of Dr. documenting the CT scan showing a C5-C6 disc protrusion and he wanted to proceed with a single epidural steroid injection to see if that helps her complaints.

It appears based on this medical record that the CT scan as performed on 10/10/07 was medically indicated since it clearly showed a C5-C6 right sided abnormality which would correlate with this persons ongoing neck and right arm radicular complaints.

The Reviewer also feels that a single cervical epidural steroid injection is medically reasonable in an attempt to treat this person's ongoing complaints and positive physical findings. The Reviewer believes the CT scan shows a clear reason why this person could be having complaints and since other conservative care has not helped, then a single epidural steroid injection of the cervical spine is medically indicated to try and treat this person's complaints without more aggressive treatment such as surgical intervention.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Neck.

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 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.

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)