



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 8/15/08

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The services under dispute include a cervical epidural steroid injection.

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

The reviewer is a physician with a specialty in Physical Medicine and Rehabilitation who has been practicing for greater than 10 years. This reviewer performs similar services in his active practice.

**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 in all its parts.

We did not receive a copy of the (ODG) Guidelines from Carrier/URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured on the job via a motor vehicle accident in xx/xx. He has been managed with conservative care including trigger point injections and an ESI

injection. This ESI was offered on 3/24/08 and provided relief for approximately 2 months of 70% efficiency. Dr. 's notes indicate "patient reports almost complete resolution of present right periscapular pain, to a much greater degree and currently duration than any of the previous five sets of TPI provided. He states this is the best he has felt in 6-8 months."

An MRI indicates right paracentral disc protrusion at C3/4 projecting 5-6mm into the spinal canal narrowing the right IVF probably compressing the exiting right C4 nerve. Also noted is right paracentral broad based disc protrusion at C5/6 compressing the anterior thecal sac.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL**

**BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE**

**DECISION.** According to the ODG, the criteria for the use of Epidural steroid injections are as follows:

- (1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. (This criterion is met)
- (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). (This criterion is met as he is a driver and wishes to avoid sedating analgesics)
- (3) Injections should be performed using fluoroscopy (live x-ray) for guidance. (This criterion is met as the first trial was performed under fluoroscopic 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. (This criterion is met as the injection is to be used therapeutically)
- (5) No more than two nerve root levels should be injected using transforaminal blocks. (This criterion is met)
- (6) No more than one interlaminar level should be injected at one session. (This criterion is met)
- (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. (This criterion is met see Dr. 's report of 4/11/08 and 6/25/08 letter by of )
- (8) Repeat injections should be based on continued objective documented pain and function response. (This criterion is met see capitol pain note of 6/11/08)
- (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. (This criterion is met as this is only the second trial)
- (10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or stellate ganglion blocks or sympathetic blocks as this may lead to improper diagnosis or unnecessary treatment. (This criterion is met)
- (11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (This criterion is met)

Because this patient meets all the requirements of the ODG, this procedure is approved.

**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)