



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 12/23/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under review include a cervical ESI at C2/3, C3/4, C4/5, C5/6 and C7/T1.

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 anesthesia and pain management and has been practicing for greater than 10 years.

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 agrees with the previous adverse determination regarding all services under review.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured while on the job on xx/xx/xx. The workup revealed a multi-level spondylosis with HNP at C5/6 and C6/7. He has been managed with PT, activity restrictions, SNRB and C6/7 ACDIF.

He has undergone a series of ESI on 7/21/08 and 8/5/08. He is currently on several analgesic medications including Vicodin and Robaxin.

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

The ODG criteria for the use of Epidural steroid injections, therapeutic are as follows:

Note: The purpose of ESI is to reduce pain and inflammation, 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. (This criterion is not met as Dr. notes do not indicate clinical signs of radiculopathy.)

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). (This criterion is met)

(3) Injections should be performed using fluoroscopy (live x-ray) for guidance (This criterion is not met as per the notes provided)

(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 not met or at least specified in Dr. notes)

(5) No more than two nerve root levels should be injected using transforaminal blocks. (This criterion is not met)

(6) No more than one interlaminar level should be injected at one session. (This criterion is not 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 not met)

(8) Repeat injections should be based on continued objective documented pain and function response. (This criterion is not met)

(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 not met)

(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 or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. (while a facet block is implied in Dr. notes, this IRO is addressing the ESI only)

(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (This criterion is met)

Secondary to the above criteria not being met, this procedure is not approved at this time. This decision is based upon the records provided and the ODG.

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)