

P-IRO Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: January 26, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Thoracic epidural corticosteroid injection at T7/8

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORHOPAEDIC SURGERY

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

Medical Records Dr. 11/07 thru 1/08
Initial Denial from 12/21/07
Reconsideration Denial 1/7/08
Physician Advisory Report 12/20/07 and 1/4/06
MRI Report 9/28/07
Electrodiagnostic Studies 12/12/07 Dr..
No ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx year old gentlemen was on a machine struck by a vehicle in xx/xx. He developed residual upper back pain and numbness in his left upper extremity. He did not improve.

MRI showed small disc bulges at T6/7 and T7/8. His electrodiagnostic studies did not show any abnormalities. Dr. wrote that the examination was normal without weakness. He wrote that “..I cannot determine the cause of the upper extremity weaknesses and paresthesias. (11/15/07)” He told the patient “that he will not benefit from any injections cause (sic) there is no nerve damage....I advised patient that he may benefit from a Cortizone (sic) injection...” (12/17/07.

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

The value of epidural injections remains in the treatment of a radiculopathy. Its value for isolated back pain or other musculoskeletal problems is questionable. There was no documentation of the thoracic disc bulges causing any radicular pain. Radicular pain at this level would involve the thoracic dermatomes along the longer lower rib margins. There is no neuroanatomical explanation why a mid thoracic disc problem would give neurological symptoms in the hands. This does not refute the man’s complaints, but only the thoracic epidural injections as a treatment option. He does not have the evidence of a radiculopathy per ODG criteria 1.

The ODG 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 with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. ([Manchikanti, 2003](#)) ([CMS, 2004](#)) ([Boswell, 2007](#))

8) Repeat injections should be based on continued objective documented pain and [functional improvement](#).

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)