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Notice of Independent Review Decision

DATE OF REVIEW: June 18, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical transforaminal epidural steroid injection, fluoroscopy, and x-ray to include CPT code 62310

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

Diplomate, American Board of Anesthesiology; Diplomate, American Academy of Pain Management

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)

PATIENT CLINICAL HISTORY:

This is a female who sustained a work related injury involving the cervical spine secondary to a lifting type mechanism. Of note, this patient has a significant past surgical history of thoracic scoliosis at the age of 16 of which she underwent thoracic fixation using Harrington rods in 1999. The Harrington rods extend from levels T4 through T12.

Subsequent to the injury a cervical MRI was performed on January 28, 2008, and revealed broad-based posterior disc bulges extending 1 mm posteriorly to mildly narrow the anterior thecal sac at the C4-5, C5-6, and C6-7 levels. At the C3-4 level, there was a right paracentral posterior osteophyte formation/disc bulge extending 1 mm posteriorly to mildly narrow the right paracentral anterior thecal sac.

From the follow-up note dated March 31, 2008, the patient is complaining of muscle pain with burning sensation in the thoracic spine on the right; upper extremity symptoms of radicular quality present in the right upper extremity, as well as subjective numbness to all of the fingers, on the right hand more than the left. The medication management at that time consisted of Celebrex, Orphenadrine, Lyrica 100 mg per day, and a Medrol dosepak.

Following this, an EMG/nerve conduction study was performed on April 2, 2008, by M.D., (board certified neurologist), revealing no neurophysiologic evidence of C5-T1 cervical radiculopathy/ulnar neuropathy/radial neuropathy/musculocutaneous neuropathy/brachial plexopathy on the right side.

This patient underwent a cervical epidural steroid injection with catheter placement on April 25, 2008. This was performed by M.D.

A post injection followup note, dated May 9, 2008, documented that the patient immediately after the injection felt a little relief, however, a day later the patient's pain returned and has not relented since. The patient did notice less numbness and tingling in the right arm, however, this has not totally resolved.

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

After a review of the information submitted, the previous non-certification for cervical transforaminal epidural steroid injections under fluoroscopy is upheld. There was a lack of significant efficacy documented with initial cervical injection of at least 50%-75% pain relief from baseline with evidence of improved function.

In addition, there does not appear to be any objective findings to support the request. The submitted radiographic imaging study and diagnostic testing to include EMG/nerve conduction study have not revealed the presence of significant radiculopathy, although the patient seems to have subjective symptoms indicative of radiculopathy.

Therefore, in accordance with ODG Guidelines, the recommendation is for upholding previous adverse determination. The Guidelines references used are Official Disability Guidelines, Treatment Index, 5th Edition, 2008 (Webb), under Cervical Epidural Steroid 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)**