



# Lumetra

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 10/26/2008

**IRO CASE #:**

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

Left C5-6 cervical ESI via catheter with fluoro and x-ray

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

Certified by the American Board of Anesthesiology  
Anesthesiology – General  
Pain Medicine – Subspecialty

### **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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	723.1	62310	Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Correspondence and documentation throughout the appeal process, including first and second level decision letters, reviews, fax cover sheets, pre-authorization requests, and request for review by an independent review organization

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Medical notes dated 10/1/08, 9/26/08, 9/11/08, 8/21/08, 7/22/08  
Operative report dated 8/21/08  
MRI cervical spine dated 10/17/07  
MRI lumbar spine dated 10/17/07  
MRI thoracic spine dated 10/17/07  
Official Disability Guidelines cited but not provided

**PATIENT CLINICAL HISTORY:**

This a male sustained a work-related injury xx/xx/xx. According to the provided medical records, he has had neck pain and left upper extremity referred pain since the date of injury. He also has back pain. An MRI revealed moderately severe to severe neuroforaminal narrowing at C5-6, left greater than right, and moderate neuroforaminal narrowing at C6-7 bilaterally.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

Per review of the Official Disability Guidelines regarding criteria for the use of epidural steroid injections, the Reviewer supports the denial for the requested procedure, cervical epidural steroid injection at the left C5-6 level via catheter with fluoroscopic guidance.

The Reviewer noted that according to the medical records, when the patient was evaluated on 7/22/08 he stated his pain score was on average at a level of 5/10. No physical examination was documented, apparently because the original dictation was lost in transcription. The patient underwent a left C5-6 cervical epidural steroid injection, performed on 8/21/08 via catheter with fluoroscopic guidance.

At the follow-up evaluation on 9/11/08, three weeks later, it is noted that the patient has had a bit less left arm pain. The day of the procedure he didn't have pain. The next day he had numbness and tingling in the arms and upper back. The pain has been on again, off again. He has a sharp pain across the upper scapula".

The patient was then seen for follow-up on 9/26/08, when it is noted that "his initial response to our first injection was favorable, but it did not last very long. The imaging studies done intraoperatively indicate there is some foraminal

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encroachment going on at C5/6 inlet. His symptoms are pretty much back to their baseline level before the first injection ...The patient's cervical radicular symptoms did not respond favorably to the first injection for anything more than a few days". At this visit a second cervical epidural steroid injection was requested, apparently because the patient desires to avoid potential surgical intervention.

The Reviewer noted that per review of the medical records, the claimant does not satisfy the selection criteria for a second cervical epidural steroid injection according to the ODG treatment guidelines. These guidelines state the criteria for use of epidural steroid injections:

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 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.
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.
11. Cervical and lumbar epidural steroid injections should not be performed on the same day.

In the Reviewer's opinion the requested procedure, cervical epidural steroid injection at left C5-6 via catheter with fluoro and x-ray, is not medically necessary for this patient, given the lack of response to the initial cervical epidural injection

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and the absence of physical examination/electrodiagnostic evidence consistent with cervical radiculopathy.

**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)

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**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME  
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**