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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Bilateral Transforaminal ESI @ C5-C6 (64479) and Fluoroscopy (77003)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Office notes, Dr. , 11/24/08, 12/15/08, 12/29/08
MRI cervical spine, 12/07/08
Office notes, Dr. , 01/07/09, 02/04/09
Peer review, , 01/26/09
Denial, , 02/21/09
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a xx year old male injured on xx/xx/xx. He has been treated for neck pain with therapy and various medications. A 12/07/08 MRI of the cervical spine showed C2-3 mild bilateral foraminal narrowing and facet arthritis and uncovertebral hypertrophy. There was a C3-4 disc osteophyte complex abutting the anterior cord, bilateral uncovertebral hypertrophy and bilateral facet arthritis, mild spinal stenosis and moderate foraminal narrowing. At C4-5 there was a disc osteophyte complex, bilateral uncovertebral hypertrophy and mild bilateral foraminal narrowing. C5-6 demonstrated a disc osteophyte abutting the anterior spinal cord to the left, bilateral uncovertebral hypertrophy, bilateral facet arthritis, and mild spinal and foraminal stenosis. There was a C6-7 disc osteophyte complex to the left, bilateral uncovertebral hypertrophy and facet arthritis with moderate right and moderate to severe left foraminal stenosis. On 12/15/08 Dr. noted the claimant had neck pain and some pain in the left shoulder. His impression after review of the MRI was spondylosis and stenosis and he recommended referral for an injection. The claimant was seen on 01/07/09 by Dr. for neck and thoracic pain. On examination there was pain with all motion, positive Spurling's and positive axial compression with pain in bilateral C5-6. Bilateral epidural steroid

injection was recommended at C5-6. The request was denied on peer review as an EMG had not been completed. On 02/04/09 Dr. reported that an EMG showed neuropathic pain without radicular pain and again recommended injection therapy. The request was not certified on peer review.

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

The evidence-based literature suggests that cervical epidural steroid injections should be reserved for individuals who have clear evidence of radiculopathy documented on physical exam and corroborated by imaging. They should have failed conservative care to date.

In this particular case, the imaging study report shows nothing more than mild foraminal stenosis at C5-6, the level of concern. Furthermore, the physical exam findings do not specifically identify signs that would show conclusive evidence of radiculopathy. EMGs were reportedly negative.

In the absence of a preponderance of arm pain and strong findings of radiculopathy and/or distinct neural compression on imaging, the request can neither be considered reasonable nor medically necessary. The patient does not meet the ODG criteria for the use of ESI. The reviewer finds that medical necessity does not exist for Bilateral Transforaminal ESI @ C5-C6 (64479) and Fluoroscopy (77003).

Official Disability Guidelines Treatment in Worker's Comp 2009 Neck and Upper Back

Criteria for the use of Epidural steroid injections, therapeutic

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

(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 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 or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.

(11) Cervical and lumbar epidural steroid injection should not be performed on the same day

Criteria for the use of Epidural steroid injections, diagnostic

To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:

(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies

(2) To help to determine pain generators when there is evidence of multi-level nerve root compression

(3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g. dermatomal distribution) but imaging studies are inconclusive

(4) To help to identify the origin of pain in patients who have had previous spinal surgery.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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