



MedHealth Review, Inc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax 469-286-0735

Notice of Independent Review Decision

DATE OF REVIEW: 2/15/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The service under dispute includes the medical necessity of a cervical epidural steroid injection.

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 Physical Medicine and Rehabilitation. The reviewer performs this type of service in an active practice and has done so for greater than 15 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 disagrees with the previous adverse determination regarding the medical necessity of a cervical epidural steroid injection.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

SORM, MD, MD and DO.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from SORM: 1/6/09 denial letter, 1/19/10 denial letter, TWCC 1 9/22/06, 10/12/06 cervical, thoracic and lumbar xray reports, 11/11/06 cervical, thoracic and lumbar MRI reports, right knee MRI report 11/18/06, neurodiagnostic report 12/18/06, 8/27/07 EMG report, 4/2/08 chest xray report, notes by Neuromuscular Institute 10/5/06 to 11/12/07, 2/28/08 to 3/3/09 notes by, MD, 11/13/08 note by, MD, 12/21/09 note by MD, DD reports of 8/14/07 and 1/31/08 by MD and 2/2/09 DD report by DO.

MD: 3/24/08 to 12/2/09 office notes by Dr, 9/28/09 appeal letter, 8/15/05 to 1/4/07 notes by Orthopedics, 4/8/08 operative report, 8/30/06 operative report, 11/18/06 left and right knee MRI report, 11/6/07 to 12/18/07 reports by, MD, 8/30/06 consult by, MD and 7/10/06 left knee MRI report.

MD: 1/12/10 preauth request letter, 7/28/09 preauth request letter, 12/29/09 exam report, 8/20/07 consult report, 6/1/09 to 12/1/09 office notes by Dr. and 12/17/09 operative report.

DO: 2/22/07 to 9/17/08 office notes.

all records provided were previously mentioned.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured on xx/xx/xx when she stumbled down stairs sustaining cervical, lumbar, and knee injuries.

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

According to the ODG: 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.

There is MRI evidence of cervical DDD at C6-7, but there is no evidence of neural impingement. Nonetheless needle EMG has verified right C7 radiculopathy on 12/6/07 and 8/27/07. However, there is no current clinical evidence >2 years after the most recent EMG to document active right sided cervical radiculopathy.

(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.

The cervical ESI may be beneficial as a diagnostic maneuver as stated by the ODG. As the patient has persistent pain, cervical MRI evidence of DDD, and EMG evidence on 2 occasions suggestive of right C7 radiculopathy the requested treatment is medically necessary.

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)