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AMENDMENT -- NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: June/30/2010
DATE OF AMENDED REVIEW: JULY 1, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
CERVICAL EPIDURAL STEROID INJECTION AT THE C6/7 LEVEL WITH IV SEDATION CONTRAST AND FLUOROSCOPY

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

PATIENT CLINICAL HISTORY SUMMARY
This is a male with primarily neck pain. The xxxx cervical spine x-rays revealed mild mid cervical spondylosis, mild disc space narrowing at C5-6 and 2 millimeters of degenerative spondylolisthesis of C4 and C5. The MRI of the cervical spine from xxxx revealed at C2-3 there were small osteophytes at the level of the uncovertebral joint with mild impression on the left C3 nerve root. At C4-5, there was a 2-3 millimeter central disc protrusion with 1-2 millimeters of central cord compression and mild impression right C5 nerve root in the neural foramen. The claimant has undergone two cervical epidural steroid injections with the last one on 01/14/10. On 01/25/10, the claimant reported 0-1/10 pain intensity and complete elimination of numbness and tingling in left arm and left side of neck. Dr. saw the claimant on 03/08/10 and noted that the cervical epidural steroid injection from xxxx had provided at least 80 percent of pain relief. On 04/06/10, Dr. evaluated the claimant and stated that the claimant was not a surgical candidate at this time unless the claimant had progression of his symptoms. Review of the records indicated motor and sensory and reflexes were normal.

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

The proposed C6-7 epidural corticosteroid injection is not medically necessary based upon review of the records in this case. If one looks towards the ODG guidelines for epidural corticosteroid injections, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The claimant has in the past been diagnosed with a C6-7 cervical disc herniation. This is apparently shown on an MRI prior to December 2009. There is an MRI report from October 2009 which does not demonstrate a C6-7 disc herniation.

The claimant did have a good response to a C4-5 and C6-7 epidural corticosteroid injection. Most recent physical examination demonstrates no neurologic deficits and normal reflexes. The impression from Dr. is that the claimant has primarily axial back and discogenic symptoms without clinical radiculopathy. Per the ODG guidelines, radiculopathy must be present to justify epidural corticosteroid injections. As no radiculopathy is present in this case, epidural steroid injections are not medically necessary as per the guidelines. <u>The reviewer finds that medical necessity DOES NOT EXIST for CERVICAL EPIDURAL STEROID INJECTION AT THE C6/7 LEVEL WITH IV SEDATION CONTRAST AND FLUOROSCOPY.</u>

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter neck and upper back, cervical epidural steroid injection

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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