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Notice of Independent Review Decision

DATE OF REVIEW: 7/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a LT transforaminal ESI at C6/7.

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. This reviewer has been practicing for more than 15 years and performs this type of service in an outpatient setting.

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 prospective medical necessity of a LT transforaminal ESI at C6/7.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 6/28/10 letter by ODG ESI passage from the neck section, 5/4/10 denial letter, 5/20/10 denial letter, 4/29/10 preauth request, clinic visit notes by MS, FNP-C from 3/29/10 through 4/28/10 script, 11/11/09 cervical MRI report, 10/20/09 cervical MRI report, clinic visit notes by Dr. from 5/11/10, DWC 69 and report by MD dated 3/5/10, 4/24/08 re-eval report by,

6/9/09 report by MD, 10/13/09 report by Dr. and a 11/25/09 cervical MRI re-read report by MD.

Dr.: clinic notes by Dr. from 1/22/10 to 6/22/10, 2/1/10 procedure report, 1/14/09 neurodiagnostic report, 10/20/09 cervical MRI report, 10/12/09 letter by MD and 1/14/10 report by DO.

A copy of the ODG was provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured in an xx while on the job. He sustained a concussion and cervical contusion. He underwent ACDIF at C5-6 in 7/05 by Dr.. He has undergone CTR bilaterally and left ulnar nerve transposition. An MRI on 11/11/09 reveals fusion at C5-6. Disc protrusion at C6-7 is observed. Left C6-7 transforaminal ESI is proposed by Dr..

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

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. *This criterion is met. There is diminished left triceps reflex with MRI evidence of C6-7.*

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). *This criterion is met.*

(3) Injections should be performed using fluoroscopy (live x-ray) for guidance. *This criterion is met.*

(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. *This criterion is met.*

(5) No more than two nerve root levels should be injected using transforaminal blocks. *This criterion is met.*

(6) No more than one interlaminar level should be injected at one session. *This criterion is not applicable.*

(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. *This criterion is not applicable. This ESI is used as a diagnostic measure as recommended by Dr. Enty.*

(8) Repeat injections should be based on continued objective documented pain and function response. *60% relief for 6-8 days is documented.*

(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. *This criterion is not applicable.*

(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. *This criterion is met.*

(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. *This criterion is met.*

ODG 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. *This criterion is met.*

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

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

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

All the criterion proposed by the ODG have been met; therefore, the requested procedure 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)