



Notice of Independent Review Decision

DATE OF REVIEW: 10/19/10

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for cervical epidural steroid injection with fluoroscopy

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

Texas licensed board-certified anesthesiologist with added qualifications in pain medicine

REVIEW OUTCOME:

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for cervical epidural steroid injection with fluoroscopy

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notification Letter dated 10/11/10.
- Adverse Determination Notice dated 9/10/10.

- UR Report dated 9/2/10.
- Doctors Report dated 7/13/10, 5/11/10.
- Peer Review Report dated 7/22/10.
- Operative Report dated 6/9/10.
- Notice of Denial dated 3/28/08.
- There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: The patient was rear ended in a motor vehicle accident.

Diagnosis: Cervical Post Laminectomy Syndrome

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

The patient had a cervical injury on xx/xx/xx that resulted in the formation of cervical cord gliosis. There was a cervical epidural steroid injection (ESI) performed on 6/9/10. A follow-up note dated 7/13/10 noted that the patient reported 1 day of benefit, but after that day the pain was worse. The ODG clearly states that in the therapeutic phase of treatment there must be at least a 50% benefit from the prior ESI lasting at least 6 weeks before further ESIs are considered medically necessary. In this case, the patient only received a one-day duration of benefit. Therefore, the request for a repeat cervical ESI is not supported. The ODG states that for ESIs to be medically necessary: “(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.” As

such, the proposed procedure, a cervical ESI with fluoroscopy, would not be considered medically necessary. Therefore, the previous adverse determination is upheld.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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, 2010.
 Neck epidural steroid injections
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).