SENT VIA EMAIL OR FAX ON
Oct/21/2010

Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Oct/21/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Transforaminal Epidural Steroid Injections C5-6

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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
OD Guidelines
Denial Letters 9/14/10 and 9/27/10
10/11/10
Medicine 2/20/09 thru 9/1/10
DDE 1/14/10
History of Treatment 9/23/09 thru 12/22/09
Medicine 6/24/10
OP Report 2/17/10 and 4/26/10
MRI 1/25/10 lumbar spine

PATIENT CLINICAL HISTORY SUMMARY
This is a man reportedly injured on xx/xx/xx. The reviewer is not addressing the lumbar issues. He had a prior history of neck pain and a cervical discectomy and anterior fusion from C6 to T1 in 1/08. He was seen by Mr. as a new patient for the Pain program on 2/20/09 for

ongoing neck and shoulder pain. His injury followed on xx/xx/xx as he reportedly struck his head. The lumbar MRI was reported. The IRO reviewer has to rely on others for the cervical MRI, as this was not provided. It reportedly showed a 2mm right paracentral disc protrusion with foraminal narrowing at C5/6 and degenerative spondylosis at C3/4. The lumbar MRI report was provided, but not the cervical one. He was requested to have a cervical ESI in January, but this was delayed by a lumbar fusion and a staph infection plus a work up for a cerebellar arachnoid cyst. Dr. noted a C7 sensory deficit. He had a translaminar cervical ESI on 4/26/10 by Dr. with a reported 60% relief in the follow up note on 5/4/10. This was only 8 days post procedure and a translaminar cervical ESI was requested then. Dr. did not feel he had a radiculopathy. Mr. stated he had a radiculitis, but did not provide any neurological loss.

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

The first issue is whether he had a radicular pain pattern. Dr. noted the reduced C7 sensation. The IRO reviewer could not determine if this was prior to the injury or not, but it was not described in the initial evaluation of 2/09. Giving Dr. his due, then we can presume this sensory loss is objective findings of the radiculopathy.

The second issue it the repeat procedure. It was requested 8 days post procedure. This man reportedly had 60% relief. The IRO reviewer presumes it was short lasting if a second procedure was considered at such a short interval. The ODG does permit consideration of a second diagnostic block after a 2-week interval. This appears to be a request for a therapeutic block. In this case, a 50% or better improvement must last at least 6-8 weeks. It appears, as noted, this lasted only 8 days.

This man does not appear to meet the ODG criteria based upon the information provided.

Epidural steroid injection (ESI)
Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy).

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 <u>and</u> corroborated by imaging studies and/or electrodiagnostic testing.

(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.

(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.

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)