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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical epidural steroid injection at C7-T1 with epidurography under fluoroscopy with sedation

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

M.D., Board Certified in pain management and anesthesiology
American Board of Anesthesiologists

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines
11/11/10, 12/8/10
Imaging 11/23/10
Medicine 11/17/08-11/30/10
Open MRI 6/14/07
Center, 4/21/10, 9/17/09, 1/30/09, 1/7/09

PATIENT CLINICAL HISTORY SUMMARY

This patient has chronic neck pain. She was injured in xxxx. She had a previous cervical fusion, C3 to C6 by Dr.

At a recent office visit on 11/30/10 this patient complains of "pain in her neck... She has numbness she said down the left upper extremity down to her hand." The exact dermatomal pattern is not described. The physical exam documents, "Spurling causes pain down her left shoulder and arm." There is no documentation describing how far down the arm the pain traveled, such as any pain in the forearm or hand. Physical exam documents minimal weakness in the left wrist extensor and decreased sensation over the "lateral part of her forearm and elbow." The right tricep reflex is 2+ and the left tricep reflex is 1+.

An MRI from 11/23/10 is significant for "moderate central and moderate to severe neural foraminal stenosis" at C6-C7.

An ESI was requested on 3/22/10 and performed on 4/21/10. At that time, the patient was complaining of neck pain and bilateral upper extremity pain. The only abnormalities on the

neurological exam at that time were “decreased sensation to her right fingertips.” This does not appear to be in a dermatomal pattern. It was also noted that, “Spurling causes pain down her shoulder on the right and down her upper extremity.” By the 5/17/10 office visit the patient reported her pain at 8 out of 10.

An ESI was also performed on 9/17/09. One note said the patient received about 6 months of relief with this ESI. On 10/20/09 she is described as having had about 80% relief, with increase in function. An ESI was performed on 1/7/09 and then again on 1/30/09 as well. On 2/24/09, she said her pain was 8 out 10. She later reported a significant amount of relief and reported that as of August 25, 2009 she thought the injection was wearing off.

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

Since this patient has received cervical ESI's in the past, this would be considered a request for a therapeutic ESI. Per the ODG, “In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks...Repeat injections should be based on continued objective documented pain and function response.” As stated above, the results of the most recent ESI are not described in enough detail that explains how much pain relief was received and if there was an increase in function noted. Also, the ODG states, “radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing.” This patient's pain pattern is never described in enough detail that allows us to decide if the pain is experienced in a radicular pattern. For these reasons, the reviewer finds that medical necessity does not exist at this time for Cervical epidural steroid injection at C7-T1 with epidurography under fluoroscopy with sedation.

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

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)