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Notice of Independent Review Decision

DATE OF REVIEW: 12/20/10 AMENDED 12/22/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a single injection (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography) of diagnostic or therapeutic substances. (62310, 77003, 72275 and 62264)

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 Orthopedic Surgery. This reviewer has been practicing for greater than 10 years.

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 single injection (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography) of diagnostic or therapeutic substances. (62310, 77003, 72275 and 62264).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Dr.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: office notes 8/20/10 through 11/22/10 by Dr., 8/17/10 initial eval by DO, 9/30/10 to 10/22/10 MMT and ROM reports, 10/15/10 cervical MRI report, undated cervical x-ray report, 11/15/10 telephone conference report, 11/10/10 procedure order, 11/16/10 denial letter and 11/23/10 denial letter.

12/2/10 letter by 11/16/10 report by DO, 11/23/10 report by DO, various studies (unreadable sources) study by The effect of spinal steroid injections for DDD, Hession et al Epidural steroid injection study, study by Riew et al. Nerve root blocks in the treatment of lumbar radicular pain, ODG ESI section, 8/20/10 script with no services checked, 8/20/10 MMT and ROM report, 9/20/10 daily PT progress note and 9/10 to 9/20/10 exercise program record.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant has been noted to have cervical pain, positive axial compression test, weakness and decreased sensation (along the 4th and 5th digits) in the upper extremities and a C6-7 disc bulge/mild stenosis (on a 10/15/10 dated cervical MRI). "Blunted reflexes and radiation of pain into the right upper extremity was also noted on that date. Lumbar pain, paresthesias at the shins and feet, along with lumbar tenderness and decreased range of motion with extension were all noted. The preceding was noted on 11/22/10. Denial letters noted the lack of facet-mediated pain at L4-5 and therefore the lack of indication for facet joint injection. In addition, the lack of clear clinical or radiographic nerve root impingement was noted to not support a cervical epidural steroid injection.

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

The neck pain, weakness and decreased sensation in portions of the upper extremity correlate reasonably with the MRI abnormality at C6-7. Nerve root impingement/"radiculopathy" is plausibly established and correlates with applicable ODG criteria for an ESI, cervical.

Per 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.
- (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), and imaging studies have suggestive cause for symptoms but are inconclusive;
- (4) To help to identify the origin of pain in patients who have had previous spinal surgery.

The ODG criteria are met for the requested services. Therefore, the procedure is found to be medically necessary at this time.

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)