



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 6/3/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a thoracic ESI at T3-T4 (62310, 36000, 76000).

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. The 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 thoracic ESI at T3-T4 (62310, 36000, 76000).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Healthcare and MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Healthcare: MD Reconsideration Request – 4/14/11, WC Pre-auth requests – 3/25/11 & 3/14/11; Pain Therapeutics – 2/11/11-3/25/11; Follow-up Evaluation Report – 2/8/11; MD Office Visit Note – 1/20/11, History and Physical Examination of the Thoracic Spine – 1/6/11; MD

Thoracic MRI report – 12/10/10; MD Cervical X-ray report – 11/12/10; PT Evaluation reports – 11/12/10-1/25/11; and PT Re-evaluation report – 12/10/10.

Records reviewed from MD were all duplicates from above.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured worker had pain in his neck and mid back. He received physical therapy for five weeks, including therapeutic exercises, therapeutic activities, manual therapy and instruction in a home exercise program.

The injured worker was seen by M.D. Physical examination revealed moderate tenderness over the thoracic paraspinal musculature on the left. There was no tenderness over the cervical or lumbar spine. The examination revealed no evidence of neurologic deficit. Medication was changed from Naprosyn to Voltaren.

On the follow-up visit January 20, 2011 Dr. prescribed a TENS unit and physical therapy for the residual back pain. The second course of physical therapy began January 25, 2011. The injured worker was still working with restrictions. On the follow-up evaluation February 8, 2011 the injured worker still had pain in the thoracic spine and shoulder. A referral was made to a pain specialist.

On February 11, 2011 the injured worker was seen by, M.D., complaining of upper back pain. Dr. diagnosed a thoracic HNP, thoracic pain and thoracic strain. He recommended diagnostic epidural steroid injection at the T6 level, times one.

On 3/10/2011 no improvement of pain was reported after the procedure. There was pain at T8-T9, T7-T6. Instructions were given regarding thoracic facet blocks.

On 3/25/2011 pain level was 7-9/10, with improvement in overall pain by less than half after the procedure (thoracic epidural steroid injection). No significant changes were noted in the physical examination since the previous office visit. Dr. planned to try a higher level thoracic ESI at T3-T4 "as per MRI per ODG guidelines, diagnostic ESI is requested. Criteria for neurological deficits, and imaging consistency and clinical findings are met".

DIAGNOSTIC STUDIES

- 2010/11/12: cervical spine x-rays were reported to be unremarkable, M.D.
- 2010/11/12 x-rays thoracic spine: unremarkable appearing thoracic spine radiographs, M.D.
- 2010/12/10: MRI of thoracic spine without contrast: Posterior 1-2 millimeter disc protrusion presses on the thecal sac in both the T3-T4 and the T6-T7 levels of the thoracic spine with no neural foraminal narrowing.

There is evidence of disc pathology at the T3-T4 and at the T6-C7 levels of the thoracic spine as well as at the C6-C7 level of the lower cervical spine. Straightening and some reversal of the thoracic kyphosis can be seen with muscle spasm or strain. M.D.

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

According to the ODG Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic), (updated 05/24/11), pertaining to Epidural steroid injections, diagnostic: Recommended as indicated below:

When used for diagnostic purposes the following indications have been recommended:

- 1) To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:
- 2) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;
- 3) To help to determine pain generators when there is evidence of multi-level nerve root compression;
- 4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive;
- 5) To help to identify the origin of pain in patients who have had previous spinal surgery.

Four of the five above-listed criteria for diagnostic epidural steroid injections are met; therefore the requested service is medically necessary. The injured worker has received one diagnostic injection. Listed among the codes for automated approval is CPT code 62310, thoracic epidural steroid injection, a maximum of two occurrences.

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)**