

CareReview™

505 N. Sam Houston Pkwy E., Suite 200

Houston, TX 77060

Phone: 832-260-0439

Fax: 832-448-9314

Notice of Independent Review Decision

DATE OF REVIEW: MAY 29, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Transforaminal cervical epidural steroid injection at C5 under fluoroscopic.

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

This physician is Board Certified in Physical Medicine and Rehabilitation with over 15 years of experience.

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)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On August 31, 2010 there is a radiology report from clinic for an MRI C-Spine w/o contrast which was dictated by MD. the impression states: mild stenosis C5-C6 secondary to broad-based disc protrusion, mild right foraminal narrowing is noted, slight cord effacement on the right; smaller disc protrusion C6-C7 abuts the cervical cord, but does not cause cord compression, the neural foramina appear to be adequate.

On October 9, 2010 there is an EMG report by MD. SLR positive. The conclusion states: this is an abnormal study, the findings are suggestive of: 1. Left L5 radiculopathy; 2. Left S1 radiculopathy; 3. Right L5/S1 nerve root compression, recommend correlation of electrodiagnostic findings with MRI of the lumbar spine to document disc pathology at the above noted levels.

On January 14, 2011 there is a recheck visit note from clinic, by D.O. the P.E. states the cervical spine reveals decreased ROM in all directions with pain to palpation over the mid cervical facets as well as mid-occipital region. Compression testing about the cervical spine is provocative for central pain without radiation. C4 through C7 dermatomes, myotomes, and reflexive zones are without deficit. The diagnoses are: cervical IVD without myelopathy; lumbosacral neuritis; myofasciitis; pain in the shoulder; pain in the knee. The treatment plan states recommends transforaminal cervical epidural steroid injection at the C5-C6, lumbar ESI at L5/S1 under fluoroscopic guidance to be performed at clinic by Dr. due to L5 and S1 radiculopathy finding on completed EMG dated 9/23/10 by Dr..

On February 10, 2011 there is a recheck visit note from clinic, by ACNP/ D.O. the P.E. states: VAS 8/10 without medications on board, claimant is tender to palpation over the L3-L4, L4-L5, and L5-S1 articulations. Range of motion is decreased in the cervical and lumbar spine with radiculitis to the bilateral lower extremities. He is tender over the cervical spine over C2-7 articulations with

radiculopathy to the left arm/left upper extremity. The diagnoses are: cervical IVD disruption without myelopathy; lumbosacral neuritis; myofasciitis; shoulder pain; knee pain.

On March 10, 2011 there is a recheck visit note by ACNP/D.O. The physical examination states VAS 7/10 with medications on board, tender to palpation over the L3-L4, L4-L5, and L5-S1 articulations. Range of motion is decreased in the cervical and lumbar spine with radiculitis to the bilateral lower extremities. He is tender over the cervical spine over C2-7 articulations with radiculopathy to the left arm/left upper extremity. The diagnoses are: cervical IVD disruption without myelopathy; lumbosacral neuritis; myofasciitis; shoulder pain; knee pain.

On April 7, 2011 there is a recheck visit note by ACNP/ D.O. The physical examination states VAS 7/10 with medications on board, tender to palpation over the L3-L4, L4-L5, and L5-S1 articulations. Range of motion is decreased in the lumbar spine with radiculitis to the bilateral lower extremities. The diagnoses are: 1. Cervical intervertebral disc disruption without myelopathy; 2. Lumbosacral neuritis. Recommendation is transforaminal cervical epidural steroid injection at the C5 and a left L5 lumbar intralaminar ESI under fluoroscopic guidance to be performed at clinic by Dr. due to L5 and S1 radiculopathy finding on completed EMG dated 9/23/10 by Dr..

On April 18, 2011 there is an authorization from the claimant that "authorized benefits be made to (the claimant) or on his behalf to the above provider for services furnished by that physician, the document also authorizes release of information to the indicated insurance carrier. This document is not signed and not dated.

On April 21, 2011 there is a letter from Carrier/Utilization Review to Provider which states a request was received for authorization and it was determined that the request does not meet medical necessity guidelines. The conclusion states: there is no clinical support for this. The physical exam is devoid of any radicular findings or is lacking all together. The MRI showed protrusions at 2 levels so there is no indication why a C5 TFE alone would be suggested, therefore it is denied.

On May 5, 2011 there is a letter from Carrier/Utilization Review to Provider which states the reconsideration has been completed and does not meet medical necessity guidelines. The conclusion states: again, as noted on previous review, there is no evidence of any upper extremity radiculopathy on exams submitted; there is not even a mention of upper extremity or neck complaints on recent office visits. There does not appear to be any rationale what so ever for the overturn of the prior adverse request determination as ODG guidelines have not been met.

PATIENT CLINICAL HISTORY:

Hypothyroid

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

The previous decisions are upheld. Per ODG Neck Chapter Under ESI Criteria #1, radiculopathy must be documented by physical exam and corroborated by imaging or electrodiagnostics. Submitted clinicals do not demonstrate objective evidence of cervical radiculopathy. The January 14, 2011 note even states that provocative compression testing leads to central pain without radiation and no neurologic deficit C4 to C7. Furthermore Criteria #2 is also not met submitted clinicals do not indicated response to conservative care.

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.

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)