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Notice of Independent Review Decision

DATE OF REVIEW: 3/12/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a cervical ESI at C6/7 62310 with fluoro (pnr 77003).

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. 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 cervical ESI at C6/7 62310 with fluoro (pnr 77003).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: the patient, MD and Clinic.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from the patient: medical expenses summary 10/1/10 to 2/17/11, 1/31/11 office notes by Dr., various DWC 73 forms, 1/10/11 DWC 69 form and report by Dr., 12/19/08 to 6/18/09 office notes by, MD, 12/19/08 to 6/19/10 office notes by, MD, 11/21/08 to 6/10/09 operative reports by Dr., undated short stay physical reports by Medical Facility, undated pain procedures reports by Medical Facility, undated spinal injections and anesthesia report (unknown party), 6/5/09 undated request for approval letter, 11/12/08 concurrent review form, 9/26/07 physical dept feedback form, 9/26/07 factors for determining case form and a mental health eval summary of 9/25/07.

Clinic: 12/30/10 denial letter, 11/22/10 to 12/20/10 office notes by Dr., 11/22/10 radiology report by Dr., 12/15/10 letter from Provider to unreadable doctor and 1/3/11 physical capabilities report.

Dr.: 2/17/11 office note and an undated medication log.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured worker (on X/XX/XX) was noted to have sustained a neck injury. Electrical studies were subsequently noted to be unremarkable and without evidence supporting radiculopathy. An 11/9/10 dated cervical MRI reflected a mildly bulged disc with neuroforaminal narrowing at C6-7 and C5-6. The claimant has been treated with medications and therapy. Decreased upper extremity reflexes were noted on 11/22/10. On 12/20/10, the claimant continued to have neck and left arm pain. Left axillary and paracervical pain was noted. A positive Spurling sign was noted, as was decreased cervical motion. The claimant was noted to have undergone prior cervical ESIs (in 11/08 and 3/09, with 4 weeks of pain relief from the first and "excellent" relief for "several weeks" of complete pain relief from the 2nd, as per the AP records dated 1/31/11. Biceps and left wrist dorsiflexion weakness were noted. The 1/10/11 dated evaluation by a Dr. was reviewed. Left arm pain and paresthesias were noted. Decreased cervical motion and grip strength were noted. "The examinee would benefit from injections" was noted.

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

The claimant's subjective findings are highly suggestive of radiculopathy, with neck and left arm pain and paresthesias. There are objective findings of motor weakness at the biceps and wrist dorsiflexors on the same side. The MRI findings reveal plausible nerve root abutment at the disc-foraminal levels at both C5-6 and C6-7. Therefore, in light of the quite reasonable response from the most recent prior ESI that allowed for a span of 2 years without another, a 3rd ESI

is reasonable and medically necessary at this time. With clinical and imaging studies corroborating each other, ODG criteria have been met as noted below.

Reference: ODG-Lumbar Spine

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

- (1) Radiculopathy must be documented. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. Radiculopathy must be 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) and injection of contrast for guidance.
- (4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the “diagnostic phase” as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be 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) *Therapeutic phase:* If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year.
- (8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

Based upon the records that have been provided for review by the above mentioned parties, the injured worker has met the criteria listed above. Therefore, the requested procedure is 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) Abdi S, et al, Epidural steroids in the management of chronic spinal pain: a systematic review. Pain Physician 2007 Jan;10(1):185-212.
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)