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Notice of Independent Review Decision

Date: 08/22/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical ESI with catheter at C5-6 level to include CPT codes 62281, 62284, 62310, 62318, 72275, 99144.

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

Board Certified Anesthesiologist
Board Certified Pain Management

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Clinical notes dated 04/05/2012, 04/13/2012, 05/16/2012, 05/31/2012, 06/22/2012 signed, physical therapy evaluation dated 04/10/2012 signed, PT, MRI of the cervical spine dated 05/22/2012 signed by Dr. clinical note dated 06/11/2012 signed by Dr. letter of medical necessity dated 06/13/2012 signed by Dr. and peer review dated 07/23/2012 signed by Dr..

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury. The patient was noted to have complaints of neck pain with radiation to her upper extremity. The clinical note dated 04/05/2012 indicated the patient presented with complaints of constant, moderate, aching and burning shoulder and neck pain. She reported pain was worse with

raising the arm and relieved with rest. She reported utilizing Loestrin-24 Fe daily, NuvaRing 0.125 mg – 0.015 mg vaginal ring, Ventolin HFA 90 mcg/inhalation aerosol 4 times a day and albuterol 2.5 mg/ 3 mL every 4 hours as needed. On physical examination, range of motion in the shoulder on abduction was 170 degrees, forward flexion 170 degrees, external rotation was equal, internal rotation was to T7 on the right and T3 on the left and strength was decreased on the right. Sensation was equal. A physical therapy note dated 04/10/2012 indicated the patient presented for evaluation. The patient was independent with supine to sit. The patient required moderate assistance with instrumental activities of daily living secondary to severe pain. The patient reported severe pain and limitation in specific work activities affecting performance. The patient reported pain was exacerbated with reaching and movement and relieved with rest and changing positions. She reported her pain as sharp, dull, cramping and radiating and rated her pain at 5/10 on the VAS. Range of motion in the right shoulder on flexion was 135 degrees, extension 55 degrees, abduction 140 degrees, internal rotation 70 degrees and external rotation 35 degrees. Strength was 4-/5 in the right shoulder on abduction, 4/5 on external rotation and flexion and 5/5 on internal rotation and extension. The clinical note dated 05/16/2012 indicated the patient presented for evaluation. The patient reported she completed physical therapy, and continued to have pain in the right side of her neck extending down the right shoulder, right hand in the median and ulnar pattern. The patient reported utilizing hydrocodone/acetaminophen 7.5/500 mg every 6 hours. The patient was recommended to continue physical therapy and medications as needed. An MRI of the cervical spine dated 05/22/2012 indicated there was no foraminal or spinal canal stenosis. There was mild broad based central disc protrusion at C3-4 and C4-5, particularly effacing the ventral subarachnoid space. There was no foraminal or spinal canal stenosis at C5-6. The clinical note dated 06/11/2012 indicated the patient presented with complaints of neck and right upper extremity pain with tingling extending into the fingers with associated weakness. Her pain was rated at 8/10 on the VAS. The pain was described as aching, sharp, burning and varied with activity. She reported pain was worse in the cervical spine, and then extended into the upper extremity on the right side all the way to the finger causing tingling into the fingers and some associated weakness. She reported utilizing Flexeril 10 mg 3 times a day and hydrocodone 7.5/325 mg every 4 to 6 hours as needed for pain. There were no neurological deficits noted in the upper or lower extremities. Deep tendon reflexes were normal. There was pain on palpation of the cervical spine and also in the right shoulder, exacerbated with extension and flexion as well as with turning the head. The patient was recommended to undergo an epidural steroid injection at C5-6. The clinical note dated 06/22/2012 indicated the patient presented for evaluation. The patient had complaints of neck and shoulder pain. She reported the pain was more localized to the neck area than previously. She had complaints of burning hot sensation in the spine. The patient reported utilizing Norco 7.5/325 mg every 6 hours. On physical examination, there was decreased range of motion of the neck. There was tenderness to palpation in the paracervical musculature.

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

The clinical documentation submitted for review does not support the requested cervical epidural steroid injection at C5-6 level. Official Disability Guidelines state epidural steroid injections are recommended as a possible option for short-term treatment of radicular pain with use in conjunction with active rehab efforts. Guidelines state radiculopathy must be documented on physical examination and corroborated by imaging studies or electrodiagnostic testing, should be initially unresponsive to conservative treatment and should be at no more than 2 nerve root levels using transforaminal blocks. This request was previously denied on 06/14/2012 by Dr. as epidural steroid injections are not medically indicated in the absence of radiculopathy. The patient's cervical MRI and physical examination findings did not support the diagnosis of cervical radiculopathy. The request was again denied on 06/21/2012 by Dr. as the letter of reconsideration did not provide any additional specific clinical information upon which to base overturning the adverse determination. There was no documentation specifically indicating distribution of subjective complaints nor were there any specific objective logical examination findings of deficits. There was still insufficient documentation submitted to indicate the need of an epidural steroid injection at C5-6 at this time. The patient had an MRI of the cervical spine on 05/22/2012 that did not indicate cervical radiculopathy. At C5-6, there was no foraminal or spinal canal stenosis. Furthermore, there was insufficient objective documentation to indicate radiculopathy on physical examination. As such, the request for a cervical ESI with catheter at C5-6 level to include CPT codes 62281, 62284, 62310, 62318, 72275, 99144 cannot be substantiated at this time, and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
Low Back Chapter, Online Edition.

FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

Reference:

Official Disability Guidelines, Low Back Chapter, Online Edition.

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. 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. (CMS, 2004) (Boswell, 2007)

(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

(9) Current research does not support a routine use of a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.

(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar 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. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)