

CASEREVIEW

8017 Sitka Street
Fort Worth, TX 76137
Phone: 817-226-6328
Fax: 817-612-6558

Notice of Independent Review Decision

[Date notice sent to all parties]: June 22, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

C6 and C7 epidural steroid injection with monitored anesthesia and fluoroscopy or epidurogram interpretation (64479, 64480, 01991, 01992, 77003, 72275)

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

This physician is a Board Certified Physical Medicine and Rehabilitation physician with over 16 years of experience.

REVIEW OUTCOME:

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

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:

07/18/06: Operative Report by, MD

05/02/11: Operative Report by, MD (L4-L5 ESI)

10/05/11: Operative Report by, MD (L4-L5 ESI)

03/30/11: UR with approval of a requested MRI of the lumbar spine

04/01/11: MRI Lumbar Spine interpreted by, MD

04/26/12: MRI Cervical Spine interpreted by, MD

04/26/12: MRI Lumbar Spine interpreted by, MD

04/26/12: Adverse Determination for Requested Left L4,5 selective nerve root block with monitored anesthesia care, to include 64483, 64484, 01991, 01992 by, DO with PRIUM

05/11/12: Office Visit by, MD with SpineCare Consultants

04/26/12: Adverse Determination for Requested Right C6 and C7 epidural steroid injection with monitored anesthesia and fluoroscopy or epidurogram interpretation and Lumbar selective nerve root block/transforaminal ESI left L4 and L5 with monitored anesthesia and fluoroscopy or epidurogram interpretation by, DO with PRIUM

05/17/12: UR performed by, DO

05/29/12: Adverse Determination for Requested C6 and C7 epidural steroid injection with monitored anesthesia and fluoroscopy or epidurogram interpretation and Lumbar selective nerve root block/transforaminal ESI left L4 and L5 with monitored anesthesia and fluoroscopy or epidurogram interpretation by, DO with PRIUM

05/29/12: UR performed by DO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to documentation in the UR reports, the claimant is a female who was involved in an incident on xx/xx/xx.

On July 18, 2006, Operative Report by, MD, Preoperative Diagnosis: Right C6-7 radiculopathy. Postoperative Diagnosis: There was concordant provocation of the right C7 root for scapular pain with poor filling of the root. The C6 had provocation in the shoulder and arm with poor filling of that root. Post-block, the patient had 100% relief. Operative Procedure: 1. Fluoroscopically guided needle localization of the right C7 nerve root, epidurogram and right C7 transforaminal epidural steroid injection under fluoroscopic guidance. 2. Fluoroscopically guided needle localization the right C6 nerve root, epidurogram and right C6 transforaminal epidural steroid injection under fluoroscopic guidance.

On April 26, 2012, MRI of the Cervical Spine, Impression: 1. Findings of _____ spondylitic changes in the cervical spine which has progressed in severity at C6-7 with severe bilateral foraminal stenosis, right greater than left. 2. C7 and T1 there is a focal disc protrusion with superior extrusion resulting in moderate focal central spinal canal narrowing. 3. Other areas of spinal canal and foraminal stenosis are visualized to a slightly less severe degree.

On May 11, 2012, the claimant was re-evaluated by, MD for complaints of low back pain and neck pain. The claimant had complaints of bilateral upper posterior neck, bilateral mid-posterior neck and bilateral lower posterior neck pain. Her current VAS score was 8-9/10. She also had complaints of right shoulder, right upper extremity, right 2 fingers and right hand pain with a VAS score of 8-9/10. Current treatment included medication and activity modification which was providing little relief of current symptoms. Medications included Neurontin 300 mg, Zoloft, Mobic 15 mg, and Norco 5/325. On physical examination the right shoulder revealed limited ROM with external rotation. She had weakness with elevation and internal rotation (glenoid labrum). Pain with elevation and internal rotation. Pinprick sensation was decreased in the following dermatomes: left L4 and L5 and right C7. Motor testing showed well developed and symmetric musculature. No evidence of any weakness bilateral C5-T1 and L1-S1. No atrophy or fasciculations were noted. Bilateral biceps reflexes were 1+/5. Bilateral brachioradialis reflexes were 1+/5. Right triceps reflex was 0/5 and left triceps was 1+/5. Spruling's testing was positive on the right. Examination of the cervical spine revealed usual pain was aggravated with flexion and right rotation. Diagnosis: Cervical Facet Arthropathy, Cervical Radiculopathy with Disc Displacement: Right C6 and Right C7. Recommendation: Cervical Selective Nerve Root Block/Transforaminal Epidural Steroid Injection: Right C6 and C7. Epidurogram Interpretation or Fluoroscopy. It was noted that she did have a right C6, C7 transforaminal ESI in 2006 which gave her good relief for up until the first

of the year with the pain and weakness worsening 6-8 weeks ago. It should be noted that a Lumbar Selective Nerve Root Block/Transforaminal Epidural Steroid Injection: Left L5 and L4 was also recommended. Other recommendations included continuing medications, continuing a home exercise program and activity modifications.

On May 17, 2012, , DO performed a UR on the claimant. Rationale for Denial: In my judgment, the clinical information provided does not establish the medical necessity of this request. In this case, there appears to be decreased sensation in the right C7 dermatome, but there is no corroboration from imaging and there is no other examination finding that would substantiate the radiculopathy except for the right Spurling's. Therefore, based on evidence-based guidelines and medical evidence provided, this request has been determined to not be supported for medical necessity.

On May 29, 2012, , DO performed a UR on the claimant. Rationale for Denial: The claimant has undergone prior ESI which did not provide significant relief for greater than 6-8 weeks. The claimant does not have significant increase in function. There is no clear documentation showing why repeat injection would be necessary at this time. No documentation showing why sedation would be necessary for this claimant. Sedation is primarily used in claimants' with extreme anxiety. No documentation from a psychologist showing that this claimant does suffer from extreme anxiety. No clear documentation showing why this procedure would be beneficial to this claimant. 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.) Documentation does not substantiate these requests at this time.

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

Denial of C6 and C7 ESI is upheld/agreed upon. Per ODG Neck Chapter, submitted clinicals do not note more recent conservative care particularly in regards to Physical Therapy/Home Exercise Program. Request for C6 and C7 epidural steroid injection with monitored anesthesia and fluoroscopy or epidurogram interpretation (64479, 64480, 01991, 01992, 77003, 72275) Is not found to be medically necessary.

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.

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)