

Independent Reviewers of Texas
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Notice of Independent Review Decision

DATE OF REVIEW: 06/08/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Appeal OP: Cervical ESI under Fluoro w/IV Sedation *no codes provided*

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

Board Certified Anesthesiologist

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:

Original determination dated 03/30/2012 and appeal determination dated 05/04/2012, clinical notes dated 01/31/2012, 02/21/2012, 03/20/2012, and 04/10/2012, MRI report of the cervical spine dated 02/15/2012, which is largely illegible due to poor copy, and CT of the cervical spine which is illegible due to poor copy.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a female with complaints of headaches, neck pain, and low back pain. On 01/31/2012, this patient was seen in clinic. She stated her symptoms were caused by a work injury on xx/xx/xx. She stated she slipped and fell in some water and then presented to clinic with head, neck, back, and left big toe pain. On exam, she had complaints of inflexibility and stiffness, as well as a dull, sharp, aching, and throbbing pain. Examination showed mild degree of pain from T1 to T12 bilaterally and severe pain intensity at occiput, C7, L1-5, and sacrum bilaterally. Triceps reflex bilaterally was 2+/5, biceps reflex 2+/5 bilaterally, and brachioradialis reflex bilaterally 2+/5. Lower extremity reflexes were 2+/5 at the hamstrings and 2/5 at the patella and Achilles. Distraction test and Jackson compression test were positive. Maximum cervical compression test was positive bilaterally. Muscle testing demonstrated 4/5 in the left cervical spine lateral flexors and right cervical spine lateral flexors. Cervical spine lateral rotators were rated at 4/5 as well as cervical spine extensors. On 02/21/2012, this patient was seen back in clinic. On exam, motor exam revealed 5/5 strength throughout and deep tendon reflexes were 2+ throughout and symmetrical. On 04/10/2012, this patient was seen back in clinic with continued neck pain radiating down to her left arm and hand associated with numbness, weakness, tingling and decreased sensation. Decreased neck range of motion and decreased grip strength was noted.

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

The original determination dated 03/30/2012 is reviewed indicating that the original request was for cervical ESI under fluoroscopy with IV sedation (no codes provided). This determination indicated that the patient experienced neck pain rated at 6/10. The patient did not present with radicular symptoms on interval exam. A complete neurological examination with quantification of motor strength was not provided to document any possible motor deficits. The radiologist reports the imaging studies were poorly scanned and largely illegible. There was no objective documentation of the patient's responses to initial conservative therapy with oral pain medication, physical therapy, or home exercises. There were also MRI findings of neural foraminal narrowing at multiple levels but only subjective sensory changes at 1 level which did not correlate. Therefore, the medical necessity of the request cannot be established and the request was non-certified. The subsequent review dated 05/04/2012 indicated that there was a poor quality copy of the MRI findings and those findings cannot be read. Furthermore, it was noted that guidelines recommend the patient be unresponsive to physical therapy and oral medications and that radiculopathy must be documented with objective findings on examination. However, the CPT codes for the procedure were not listed. Without the CPT codes, the level of the epidural steroid injection cannot be documented and without physical therapy notes, and clear imaging studies and/or electrodiagnostic studies, the medical necessity of the request cannot be substantiated and therefore the request is non-certified. The medical records submitted for this review also include imaging studies which are of poor quality and cannot be read. The medical records submitted for this review also failed to indicate significant current conservative care prior to undergoing this intervention. Additionally, the CPT codes have not been provided to indicate the level of the requested procedure. Therefore, the request is not considered reasonable and necessary.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines, Neck and Upper 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. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.

([Andersson, 2000](#)) 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.)