

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: February 29, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral transforaminal epidural steroid injections (TESI) at T6-7, T7-8 and T8-9 (64479-50, 64480-50, 64480-50, J1040, and Q9967).

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

M.D., Board Certified in Neurology.

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 requested service, bilateral transforaminal epidural steroid injections (TESI) at T6-7, T7-8 and T8-9 (64479-50, 64480-50, 64480-50, J1040, and Q9967), is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 2/13/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 2/14/12.
3. Notice of Assignment of Independent Review Organization dated 2/14/12.
4. Patient Medical Records from MD dated 1/18/12 and 12/21/11.
5. Patient Medical Records from The Orthopaedic Surgery Group and Center for Sports Medicine dated 10/25/06.
6. MRI of Cervical Spine dated 8/26/09.
7. MRI of Thoracic Spine dated 8/26/09.
8. Denial Documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was involved in a work related accident in xxxx in which he was struck by a forklift and suffered an injury to his neck. Since that time, he has had persistent neck pain and pain in his upper extremities. The patient has reported difficulty completing several activities of daily living. He has been treated with muscle relaxants, anti-inflammatory medications, chiropractic therapy, and interventional pain procedures. The patient has reported no relief from the chiropractic therapy, approximately 50% relief from the medications, and approximately 70% relief from the interventional pain procedures. His MRI demonstrated multilevel cervical spondylotic changes greatest at C6-7 with disc protrusion, canal stenosis and foraminal narrowing, disc protrusions at C3-4, C4-5 and C6-7, thoracic multilevel spondylotic changes with moderate central extrusion at T6-7, a small to moderate left central herniation at T7-8 and small right central herniation indenting the anterior thecal sac at T8-9. Bilateral transforaminal epidural steroid injections (TESI) at T6-7, T7-8 and T8-9 have been requested. The URA has denied this request based on a lack of medical necessity.

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

This patient presents with neck pain radiating into his upper extremities. A subcommittee of the American Academy of Neurology concluded that there is insufficient evidence to make recommendations for the use of epidural steroids to treat cervical radicular pain. As noted in the Official Disability Guidelines (ODG), "The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain." Review of the published, peer-reviewed literature

reveals insufficient evidence to conclude that thoracic epidural steroid injections are safe and effective for this patient's condition. Given the lack of evidence supporting the proposed therapy in this clinical setting, the requested bilateral transforaminal epidural steroid injections (TESI) at T6-7, T7-8 and T8-9 (64479-50, 64480-50, 64480-50, J1040, and Q9967) are not medically necessary for treatment of the patient's medical condition.

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
ODG Treatment. Integrated Treatment/Disability Duration Guidelines. Neck and Upper Back (Acute & Chronic).
- 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

1. Armon, C., et al. Assessment: Use of epidural steroid injections to treat radicular lumbosacral pain. Report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. *Neurology*, 2007;68:723-9.
2. Abdi, S., et al. Epidural steroids in the management of chronic spinal pain: A systematic review. *Pain Physician*, 2007;10:185-212.

[] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)