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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 9/24/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of a cervical Epidural Steroid injection with catheter, under fluoroscopy and IV sedation C4/5.

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 Epidural Steroid injection with catheter, under fluoroscopy and IV sedation C4/5.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties: Dr. and .

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: 4/16/12 to 8/20/12 office notes from, 5/9/12 operative report, 2/1/12 cervical and thoracic MRI reports, and 2/9/12 thoracic x-ray report.

: 8/22/12 denial letter, 8/9/12 report by MD, preauth form by Dr. (not apparently dated), 7/10/12 denial letter, 7/10/12 report by DO, and 7/5/12 preauth form by Dr..

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The was noted to have been injured while unloading a large container of toilet bowls. Purportedly up to seven toilet bowls fell onto the top of the claimant at the level of his head, neck and upper back. Clinical and radiographic findings rendered support for diagnosis of cervical spondylosis. Provider records including from Dr. (from the spring and summer of 2012) were reviewed including most recently from 7-23-12. The claimant was noted to be a “mesomorph” with a 6’2” 240 lb. body size. The provider’s patient had indicated a greater than 70% improvement with regards to neck pain after the initial epidural steroid injection that had been performed on 5-9-12. The pain was noted to have been returning back to approximately 40% to 50% improved as of 7-23-12.discussed chronic neck and left upper extremity pain associated with numbness, tingling and weakness. Failure of responses to rehabilitation was documented. Exam findings have revealed a positive Spurling sign, decreased range of motion of the cervical spine and decreased sensation in the C-4-five distribution along with mildly decreased handgrip strength. A prior cervical MRI scan report dated 2-10-12 revealed a central disc protrusion at C4-five with mild left neural foraminal narrowing. Denial letters included the lack of duration of response from the initial epidural steroid injection along with the unknown level of injection and the rationale for the utilization of IV sedation.

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

The claimant has had a documented guideline criteria associated response to the initial epidural steroid injection. The level of injection has now been provided. The rationale for the intravenous sedation clearly is associated with the fact that the claimant has a mesomorphic body habitus that renders such an epidural steroid injection to be challenging at best. Examination findings do reveal objective evidence of clinical radiculopathy that is corroborated by the MRI imaging study. Therefore at this time, applicable guideline criteria for a repeat cervical epidural steroid injection, including with fluoroscopy and intravenous sedation have been met.

Reference: ODG Cervical Spine; criteria for the use of Epidural steroid injections, therapeutic:
(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.

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)**