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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 1/31/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of injection; anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level (a cervical epidural injection, CPT 64479).

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 an injection; anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level (a cervical epidural injection, CPT 64479).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed: 1/15/13 letter, 12/20/12 denial letter, 12/21/12 letter, 12/28/12 denial letter, 12/20/12 report from, 12/27/12 report, 12/17/12 preauth request, 11/18/10 to 12/10/12 letters, 9/28/12 operative report, 9/28/12 Cervical

Myelogram report, 9/28/12 cervical CT report, 5/10/11 cervical x-ray report, 10/26/10 discharge summary, 10/26/10 operative report, 10/26/10 history and physical report, 10/3/12 cervical Myelogram report, 10/3/12 cervical CT report, 9/28/12 intrathecal contrast report, 9/30/09 history and physical report, 9/30/09 operative report, and 5/11/10 operative report.

4/6/09 to 12/10/12 letters, 5/14/09 MRI report, 4/6/09 to 5/10/11 cervical x-ray reports, , 10/1/09 electrodiagnostic report, 10/17/11 letter, 8/13/10 cervical myelogram and CT report, 6/22/10 cervical MRI report, 1/17/03 cervical myelogram, 6/29/87 letter, 6/12/87 lumbar MRI report, 5/28/87 to 11/24/2003 office notes, 7/19/87 to 4/16/91 lumbar myelography reports, 7/21/87 operative report, 7/21/87 to 11/2/88 pathology records, 11/1/88 operative report, 2/22/91 lumbar MRI report, 4/16/91 operative report, 9/23/91 letter, 7/27/92 letter, 5/8/97 to 8/13/98 letters, 7/29/97 cervical MRI report, 4/25/97 cervical myelogram/CT report, 10/16/98 lumbar myelogram report, 5/5/99 operative report and discharge summary, 5/27/99 and 1/29/01 lumbar radiographic reports, 1/5/01 operative report, discharge summary, and radiology reports, 1/5/01 electrodiagnostic studies, 7/25/02 cervical radiology report, 8/14/01 lumbar myelogram report, 4/11/01 cervical follow up report, and 6/5/09 operative report.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The male is known to have been injured while working in xx/xxxx. The claimant had neck pain with radiation to the shoulders and underwent discectomy and fusion at C5-6 and C6-7. Reportedly a treatment involving manipulation resulted in a second operative procedure/fusion, this time at C4-5. The claimant has had recurrent neck pain with weakness in the extremities. Exam findings have revealed weakness of extremities, along with a positive sign (L'Hermitte) consistent with myelopathy. Records also reveal epidural steroid injections in 2010 (prior to the second operative procedure) without significant positive effect. A 9/28/12 dated CT scan with myelogram revealed degenerative disc disease and postoperative changes multiple levels of the cervical spine. Mild cord deformation was noted at C2-3, C3-4 and C4-5. Incomplete fusion was noted at C4-5, along with broken screws. A 12/10/12 dated letter from the AP discussed the trial and failure of medications including narcotic analgesics. On 12/12/12, the AP discussed the patient's neck pain with increasing weakness and numbness in all four extremities. A temporizing CESI was considered for pain relief, with future surgical intervention at C3-4. Denial letters noted the lack of objective findings of cervical radiculopathy corroborated by imaging studies. It was also noted that prior epidural steroid injections had no significant effect. It was noted that there was a lack of indication of which cervical level was being considered for injection. In addition, the lack of recent comprehensive less invasive treatment was also noted.

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

This claimant has evidence of clinical and a radiographic myelopathy attributable to spinal cord compression. This clinical situation represents a condition more severe than objective clinical and imaging associated radiculopathy. The spinal cord itself represents essentially a series of nerve roots and greater neurogenic pathways. Less invasive methods such as medications and restricted activities were tried and failed. Subjective and objective findings do correlate with the imaging CT-myelogram and are associated with spinal cord impingement. The AP indicates that the treatment is for pain control prior to a more definitive procedure. There is a plausible potential benefit in the proposed ESI, on the basis of reduction in inflammation due to cortisone and reduction in pain due to analgesics. The choice of one injection level is noted and to be under fluoroscopy, as per guidelines. In this severe clinical condition (with multiple cord levels being plausibly affected clinical and on imaging); the proposed procedures are reasonable and medically necessary. Applicable guidelines for a therapeutic ESI have been met at this time; therefore, the procedure is medically necessary at this time.

Reference: 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.

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)