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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 6/30/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a right C4/C5 ESI under fluoroscopy.

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 right C4/C5 ESI under fluoroscopy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed.

These records consist of the following (duplicate records are only listed from one source): Records reviewed: 4/23/13 denial letter, 3/15/13 denial letter, 6/6/13 fax cover, 6/6/13 letter, 3/5/13 script for, 11/14/11 cervical MRI report, 3/26/13 office note, 3/5/13 office notes, 3/21/13 treatment order, 1/15/13 to 3/21/13 progress notes, 6/8/12 DWC 69 and report, 1/15/13 medication script, 3/12/13

preauthorization request, 1/17/13 order requisition form, 1/21/13 initial eval, 1/17/13 office note, and 1/8/13 operative report.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a male was noted to have fallen backwards onto a van and then onto concrete, on xx/xx/xx. He was noted to have strained the cervical spine region. The claimant has had persistent pain and tenderness, along with an 11/14/11 dated MRI revealing a disc protrusion with cervical cord impingement at C5-6, along with multiple levels of disc protrusions. The neurological exam was noted to reveal decreased sensation in the C5-6 dermatomes on the right. There were “generally hypoactive” upper extremity reflexes and “winging of the right scapula.” As of 3/26/13, the patient had been treated with medications and PT. Denial letters indicating a lack of objective evidence of radiculopathy and/or detailed and recent comprehensive nonoperative trial and failure.

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

The claimant has both subjective and objective findings that are compatible with a diagnosis of radiculopathy. The clinical findings have an equivocal relationship to the MRI abnormalities noted. There has been a reasonable trial and failure of therapy, medications and restricted activities.

For diagnostic purposes; the request is reasonable “(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.”

In addition, when considered as treatment “(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.” Therefore, both for diagnostic and treatment purposes, the request is reasonable and medically necessary at this time.

Reference: ODG Cervical Spine Chapter

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)