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Notice of Independent Review Decision

DATE OF REVIEW: September 6, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient Left C5 and C6 Catheter Assisted Epidural Steroid Injection (ESI) with Fluoroscopy 62310 x 2.

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

M.D., Board Certified in Orthopedic Surgery.

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)

I have determined that the requested outpatient left C5 and C6 catheter assisted epidural steroid injection (ESI) with fluoroscopy 62310 x 2 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 8/14/13.

2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 8/16/13.
3. Notice of Assignment of Independent Review Organization dated 8/19/13.
4. Denial documentation dated 7/19/13, 8/12/13 and 8/21/13.
5. MRI Spine dated 7/10/13.
6. Clinic notes dated 3/15/11, 6/14/11, 9/15/11, 12/13/11, 9/11/12 and 12/11/12.
7. Clinic notes dated 3/13/12, 6/12/12, 3/25/13 and 6/25/13.
8. Patient's Treatment History.
9. ODG-TWC: ODG Treatment Integrated Treatment/Disability Duration Guidelines – Neck and Upper Back (Acute & Chronic).

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work related injury on xx/xx/xx where he slipped and fell. At an office visit on 3/15/11 he reported pain in the thoracic area, primarily in the mid and lower thoracic area going down to the left mid and lower lumbar area that radiated to his left buttock. He reported associated stiffness and paravertebral muscle spasms and reported narcotics and muscle relaxant medications had made some improvement. Upon exam he had no evidence of ischemia or infection and had normal gait and had no laxity or subluxation of any joints. Cranial nerves 2 through 12 were intact. Assessment was thoracic spondylosis and cervical spondylosis with myelopathy. During an office visit on 6/14/11 he reported headaches and neck stiffness at that time and reported conservative therapies included narcotics, muscle relaxants, and non-steroidal anti-inflammatories with some relief. Upon exam he demonstrated cranial nerves 2 through 12 were intact and there was no evidence of infection or laxity in any joint examined. He stated this pain radiated to the left side, going to the occipital scalp and left shoulder. Upon exam there was no evidence of ischemia or infection, he had a normal gait, and no laxity or subluxation of any joint was noted. Cranial nerves 2 through 12 were intact. During an office visit on 9/15/11 he reported improvement in his function on daily activities and reduction in overall pain with medication usage and pain scale was rated at 4-6/10 with medications. Cranial nerves 2 through 12 were again intact and he had a normal gait. During an office visit on 10/13/11 he reported pain with medications at 4/10. He was seen initially on that date for his lumbar spondyloarthritis and he was continued on medications. Upon exam he had cranial nerves 2 through 12 intact and normal gait.

On 3/13/12 the patient rated his pain at 3/10 to 4/10 and upon examination he had a normal gait and cranial nerves 2 through 12 were intact. On 6/12/13 the patient reported continued discomfort of the left side of his neck that radiated to the occipital scalp, left shoulder, left arm, and left forearm. He denied motor weakness. An exam revealed normal gait and cranial nerves 2 through 12 were intact. On 9/11/12 he reported stiffness and paravertebral muscle spasms to his lumbar spine and did note some pain relief with arrested medications. Upon exam he remained unchanged with a normal gait. On 12/11/12 his pain was rated at 4/10 with medications. On exam he had no evidence of gait abnormalities and no laxity or subluxation of any joints was noted. He was continued on medication management.

On 3/25/13 the patient reported discomfort to the left side of his neck with headaches, stiffness, and paresthesias in his left upper arm and forearm. A physical exam revealed cranial nerves 2 through 12 grossly intact and he had a normal gait. He was continued on medication management. On 6/26/13 the patient continued to report headaches, neck stiffness, and paresthesias. Upon exam he remained unchanged with a normal gait and cranial nerves 2 through 12 were intact. Upon further exam he had normal sensory exam of C1-T2 to light touch and pain, deep tendon reflexes were 2/4 bilaterally in the upper and lower extremities and muscle strength testing was considered 5/5 in all muscle groups tested of the upper and lower extremities with the exception of left biceps which was rated at 4/5. He had full active range of motion with extension and limited range of motion with flexion and rotation. He had a positive Spurling test. On 7/10/13 an MRI of the cervical spine was obtained demonstrating mild degenerative disc disease and spondylosis most pronounced at C5-6 where changes resulted in moderate bilateral neural foraminal narrowing.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the URA's denial stated that there was no objective evidence of increased function or decreased medication usage resulting from the previous injection. The URA further stated that the most recent progress notes do not include objective findings of specific dermatomal deficits attributable to a C5-6 nerve root impingement.

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

In this patient's case, Official Disability Guidelines (ODG) do not support the requested outpatient left C5 and C6 catheter assisted epidural steroid injection (ESI) with fluoroscopy 62310 x 2. Per ODG criteria, there should be documentation of radiculopathy with correlation with imaging studies, and guidelines state that one injection should be performed with another injection considered medically necessary after efficacy of the first injection has been demonstrated for a period of time. In this case, the efficacy of the last injection was not completely documented and there is lack of documentation of significant radiculopathy on exam that can be correlated with the C5-6 level. Furthermore, there is lack of documentation of significant current conservative care other than medication management. As such, there is lack of documentation of significant current conservative care and lack of documentation of radiculopathy that can be correlated with imaging studies. All told, the requested outpatient left C5 and C6 catheter assisted epidural steroid injection (ESI) with fluoroscopy is not consistent with ODG criteria and therefore is not supported as medically necessary.

Therefore**,** I have determined the requested outpatient left C5 and C6 catheter assisted epidural steroid injection (ESI) with fluoroscopy 62310 x 2 is 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**
- ☐ **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)**