



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**Date notice sent to all parties:** 8/10/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

The item in dispute is the prospective medical necessity of NJX DX/Ther SBST Epidural / Subrach C, M-Sedaj By SM Phys Perfrmng Svc 5+ Yr, and Fluor GID & Loclz Ndl/Cath SPI DX/Ther.

**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 Anesthesiology.

**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 agrees with the previous adverse determination regarding the prospective medical necessity of NJX DX/Ther SBST Epidural / Subrach C, M-Sedaj By SM Phys Perfrmng Svc 5+ Yr, and Fluor GID & Loclz Ndl/Cath SPI DX/Ther.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male injured on xx/xx/xx during an altercation. The patient has been diagnosed with cervical radiculitis. The patient is currently on Neurotin. An MRI on 04/03/2015 reported cervical spondylosis at C6-C7 with narrowing of disc height and 1.8 mm symmetric spur and disc protrusion and mild indentation of the cord. Modest canal stenosis with anteroposterior canal diameter narrowed to 8.8 mm. Mild annular disc bulging or spur formation was present at C2-C3, C3-C4, and C4-C5, measuring up to 1.3 mm. No cord compression was produced. There was bilateral foraminal narrowing at C4-C5 and predominantly at C6-C7. On 05/06/2015, evolution noted subjective complaints of posterior neck and upper back pain that radiated to both upper extremities. The physical

examination demonstration limited active range of motion of the cervical spine. Muscle strength was 5/5. There was no atrophy.

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

The requested medication is to be used for use with an active disease process. The claimant does not have an active disease process that would necessitate this therapy. The request is for Subsys (Fentanyl sublingual spray 1200 mcg). Per FDA guidelines, Subsys is only approved for the treatment of opioid resistant breakthrough cancer pain. Use of this medication in this claimant would be considered off-label. Therefore this request is non-certified.

The Official Disability Guidelines, 19th Edition Low Back Chapter

Epidural steroid injections (ESIs), therapeutic

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

(1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be 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) and injection of contrast for guidance.

(4) Diagnostic Phase: At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block ((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) Therapeutic phase: If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70 percent pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of

pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)

(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

(9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.

(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar 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. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

**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)