

# I-Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jul/29/2009

**IRO CASE #:**

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

Cervical Epidural Steroid Injection, 62310

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

MD, Board Certified Orthopedic Surgeon

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Adverse Determination letters, 06/12/09, 07/02/09
2. Center for Neurological Disorders, 07/15/09, 04/07/09, 03/10/09
3. Letter to IRO, 07/16/09
4. Appeal, 05/19/09
5. Physical therapy, 04/29/09
6. Evaluation Center, 05/01/09
7. Medical and Surgical preauthorization request, M.D., 06/03/09
8. Request for reconsideration, 06/30/09
9. M.D., 03/10/09
10. ODG Guidelines and Treatment Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker.. He hit his head on a car doorframe on xx/xx/xx. He had an MRI scan which showed, according to the report, very mild cervical spondylosis without canal stenosis or significant neural foramen encroachment. There was noted to be a negative neurological examination. There was also noted to be a negative EMG/nerve conduction study on 09/10/08. All the studies have been stated to be normal. The patient complains of some neck pain and headache and some numbness and tingling into the upper extremities but without any focal numbness, motor loss or neurological deficit. He has been recommended for an epidural steroid injection at this time.

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

Based upon the Official Disability Guidelines and Treatment Guidelines, the use of epidural steroid would be indicated in patients with radiculopathy. In this particular situation, there is neither subjective history complaints, objective physical findings nor objective diagnostic testing findings that would be indicative of radiculopathy. The requesting physician has not given this reviewer an explanation of why the ODG Guidelines should be set aside in this particular instance. The request does not meet the ODG guidelines. The reviewer finds that medical necessity does not exist for Cervical Epidural Steroid Injection, 62310.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)