

I-Decisions Inc.

An Independent Review Organization
71 Court Street
Belfast, ME 04915
Phone: (207) 338-1141
Fax: (866) 676-7547
Email: manager@i-decisions.com

DATE OF REVIEW:

May/04/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Epidural Steroid Injection w/wo contrast; diagnostic/therapeutic (62310)

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

This is a male with cervical pain. He had a previous epidural steroid injection with no documentation of improvement. He has been on various medications including Vicodin and Lyrica. An MRI scan shows spondylosis and facet arthropathy with some C6/C7 stenosis. The patient has not been documented to show any signs of radiculopathy. The medical provider has requested a cervical epidural steroid injection.

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

Based upon the ODG Guidelines for ESI, it would be necessary in this case for this patient to have either documented radiculopathy, clinical examination with supporting imaging and/or EMG studies. It would be necessary in this particular instance for there to have been some improvement with the initial epidural steroid injection. Most importantly in the records, radiculopathy has not been documented. Furthermore, the provider requesting this treatment has not provided an explanation for why the ODG should be set aside in this instance. It is for these reasons that the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for Cervical Epidural Steroid Injection w/wo contrast; diagnostic/therapeutic (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)