



MedHealth Review, Inc.  
661 E. Main Street  
Suite 200-305  
Midlothian, TX 76065  
Ph 972-921-9094  
Fax 972-775-6056

---

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 4/30/2010

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a cervical epidural steroid injection at C7-T1.

**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 Physical Medicine and Rehabilitation. This reviewer performs this type of service in active practice and 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 agrees with the previous adverse determination regarding the prospective medical necessity of a cervical epidural steroid injection at C7-T1.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from HDI: MD Office Visit Notes – 3/12/10 & 3/26/10; MD Cervical MRI report – 3/5/10; and Nova Referral Slip – 3/10/10. Records reviewed from MD: Pre-auth request – 3/15/10-4/8/10; HDI denial letters – 3/18/10 & 4/2/10; MD History and Physical report – 3/12/10.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical documentation provided, this individual is described as a -year-old man injured in a fall from about 15 feet. Medications have included Tylenol. There is no surgical history in relationship to this injury. He has undergone diagnostic studies and some non-describe4d physical therapy. A MRI of the cervical spine has indicated as of 3/5/10 significant compromise of the C6-7 left neural foramen secondary to a lateral left disk protrusion without compromise of the spinal canal. No disk herniation is reported. The patient has come under the medical treatment of MD who is dealing with pain management treatment.

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

Utilizing the ODG criteria, the submitted objective information from the requesting physician does not meet the ODG criteria to support medical necessity of a cervical ESI. The ODG does indicate the necessity for there to be a substantial documentation of a radiculopathy by clinical decisions and examination as well as electromyographic diagnosis consistent with imaging changes to support the presence of a radiculopathy. In the examinations submitted by the requesting provider, there is no clinical examination identifying changes in reflexes, evidence of atrophy, dermatomal sensory loss, or strength measurements, as well as no electrodiagnostic evidence to confirm the changes noted on the MRI to support a diagnosis of cervical radiculopathy per ODG criteria.

**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)**