

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Nov/08/2010

**IRO CASE #:**

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

Left C5/6 and C6/7 Epidural Steroid Injection and Epidurogram

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

MD, Board Certified in Physical Medicine and Rehabilitation with expertise in pain management, wound management and geriatrics. Medical Director of Rehabilitation.

**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**

10/1/10, 10/6/10  
Back Institute 10/13/08 to 10/14/10  
M.D. 6/17/10 to 9/23/10  
Health Center for Diagnostics & Surgery 7/8/10  
AOSM 8/10/10  
D.O. 8/26/10, 6/24/10  
6/24/10  
ODG Neck Chapter

**PATIENT CLINICAL HISTORY SUMMARY**

This claimant is xx. He had a previous cervical spine injury x/xx/xxxx. He did have ESI at that time that helped in alleviating the radiating pain he had in his RIGHT arm. He did return to work. He states he was symptom free. He then was working when he fell backward and was injured on xx/xx/xx hitting his head and left elbow. He again complains of neck pain with left upper extremity/elbow pain and left upper extremity weakness. He did have an MRI that shows 2-3 mm protrusion of the Right C5/6 disc and Left C6/7 disc and at thoracic T12. There is facet hypertrophy. EMG shows left median sensory motor neuropathy. There is no radiculopathy. He uses Ultracet and Xanax for pain and muscle spasm. Dr. performed an independent DD exam and indicates the patient has a cervical disc syndrome with myelopathy and there was aggravation of a previous injury.

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

In this instance there is evidence of radiculopathy clinically. There is left upper extremity weakness. There is evidence of disc protrusion on MRI. In the past ESI was helpful in alleviating the right radicular symptoms. ESIs are recommended as an option for treatment of radicular pain. Radiculopathy should be documented by physical examination and corroborated by imaging studies or electrodiagnostic testing. It should first be unresponsive to conservative treatment. (NSAIDS, exercises, muscle relaxants) In this case, conservative care is not well documented and medication management has not been maximized. This does not meet the ODG criteria for an ESI at this time. The reviewer finds that there is not medical necessity at this time for Left C5/6 and C6/7 Epidural Steroid Injection and Epidurogram.

**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)