



Notice of Independent Review Decision
IRO REVIEWER REPORT

DATE OF REVIEW: 9/10/10

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for cervical epidural steroid injection C5-6 CPT codes 62264, 62310, 77003 and 72275

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

Texas licensed orthopedic surgeon

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- X Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for previously denied request for cervical epidural steroid injection C5-6 CPT codes 62264, 62310, 77003, and 72275

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Orthopedic Report dated 8/16/10.
- Adverse Determination Letter dated 8/6/10, 7/28/10.
- Email Report dated 7/28/10.
- Procedure Orders dated 7/23/10.
- Orthopedic Consult dated 7/16/10.
- Cervical Spine MRI dated 5/28/10.
- Right Shoulder MRI dated 5/28/10.
- Right Knee MRI dated 5/26/10.
- Initial Consultation dated 5/10/10.
- Radiology Report dated 5/10/10.
- Pre-Authorization Request (date unspecified).
- Article (date unspecified) x3

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Driving a standup lawnmower when the mower switched into second gear and threw the claimant off to the side, causing him to land on his right knee and shoulder and jerk his neck.

Diagnosis: Protrusion at C4-5 and C5-6 with right C6 radiculopathy.

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

This male with a work-related injury date of xx/xx/xx is being evaluated for a request for cervical epidural steroid injection (ESI) at C5-6.

The claimant's diagnosis was "protrusion C4-5, and C5-6 with right C6 radiculopathy." The mechanism of injury occurred when the claimant was at work as a small engine mechanic and he was driving a standup lawnmower. The mower switched into second gear and threw the claimant off to the side causing him to land on his right knee and shoulder and jerk his neck.

The claimant had a 5/28/10 cervical MRI report indicating a 2 millimeter annular symmetric bulge of the disc at C4-5. The anterior posterior dimension of the central canal narrowed to 9 millimeter. There was no definite extrinsic compression against the exiting nerve root sleeves. At C5-6 there was a 2 millimeter broad-based extradural defect, probably spondylosis, extending to the anterior surface of the cord with the anterior posterior dimension at 9 millimeter. There was slight neural foraminal narrowing bilaterally mainly on the right but no impingement of exiting nerve root sleeves.

The claimant had an 8/16/10 orthopedic evaluation where he reported neck pain that was 4/10 with discomfort with side-to-side movement, soreness, and stiffness. The claimant reported numbness and tingling in his hands present bilaterally. Examination of the claimant's cervical spine revealed severe tenderness and decreased range of motion in all directions limited by pain. The claimant had positive axial compression sign and a positive Spurling's sign reproducing his right arm and shoulder pain. The claimant continued to have diminished sensation along his right C6 distribution as well as weakened wrist dorsiflexors on the right. The claimant's diagnosis was protrusion at C4-5 and C5-6 with right C6 radiculopathy. The treatment proposal for the claimant was cervical ESI, "hopefully this will help with some of his radiculopathy and we can avoid any surgical intervention of the neck."

The Official Disability Guidelines (ODG) were utilized with respect to criteria for ESIs. According to the ODG criteria, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In the claimant's case, the MRI report as noted above revealed "no definite extrinsic compression against the exiting nerve root sleeves" at both C4-5 and C5-6. Therefore, there was no radiographic evidence

of a neurocompressive lesion that can support the diagnosis of C6 radiculopathy in this claimant, despite the findings on the claimant's physical examination.

Despite the claimant's apparent physical examination findings of diminished sensation along the right C6 and weakened wrist dorsiflexor on the right, there was no imaging study corroboration or substantiation of a neurocompressive lesion involving the C6 nerve root. Radiculopathy has, therefore, not been objectively documented as required by the ODG, and, therefore, a request to proceed with a cervical ESI at C5-6(62310) cannot be considered medically appropriate. CPT codes 62264 (epidural lysis of adhesions) is not applicable to the cervical spine. Because the ESI is denied 77003 (fluoroscopy) and 72275 (epidurogram) are not necessary. Therefore, the previous adverse determination is upheld

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
Official Disability Guidelines Treatment in Worker's Comp, 15th Edition, 2010 Updates, Neck and Upper Back – Epidural Steroid Injections
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).