

Notice of Independent Review Decision

DATE OF REVIEW: 02/11/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of cervical ESI (62310) and fluoroscopy (77003) for the cervical spine.

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

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)

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.

Upon independent review, the reviewer finds that the previous adverse determination should be overturned

Reviewing both the original preauthorization denial as well as the reconsideration denial for cervical ESI with fluoroscopy, the reviewers did utilize the *ODG* for the therapeutic ESI. In the *ODG*, therapeutic ESI is fairly specifically identified as requiring objective or reasonable evidence documenting a radiculopathy, whether

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in the cervical or lumbar region. The denials appear to be primarily based on the fact that there were no specific clinical or diagnostic findings supporting the mild MRI changes noted on the MRI studies. Because there was no definitive evidence of radiculopathy, the recommendation for authorization was to deny the service. As this individual has undergone a prolonged period of symptoms, physical therapy and medication treatment, and trigger point injections and still remains symptomatic, the diagnosis still is uncertain. The utilization of a diagnostic ESI in order to establish a diagnosis, which has not been clarified, is supported by the *ODG*. Based on the need to clarify the patient's pain generator, one cervical ESI with fluoroscopy is reasonable and necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The information provided indicates that this individual is a xx-year-old lady who was injured at work. She fell down several flights of stairs and sustained multiple injuries involving the neck, shoulders, wrists, and knees. She underwent bilateral carpal tunnel release and right subacromial decompression surgeries. MRI of the cervical spine 06/09 demonstrated small disk protrusion at C4-5 and C5-6 without cord flattening or canal stenosis. There was small disk protrusion at C6-7. She underwent physical therapy to the neck, utilized medication for pain, but resulted only in temporary relief. She continued with persisting pain in the neck area despite the surgeries involving the carpal tunnel and shoulder. She does have some pain symptoms radiating into both upper extremities but apparently not into consistent, specific dermatomal patterns. She notes numbness and tingling sensation in the arm and hand areas. She also notes tightness and spasming in the neck area. She describes headache as well. Regular daily activities increase her pain symptoms

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

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Official Disability Guidelines (ODG), section on treatment of neck pain for diagnostic ESI.

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

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- TMF SCREENING CRITERIA MANUAL**

- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION)**

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**