



**Notice of Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)**

DATE OF REVIEW: 06/14/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical Epidural Steroid Injection

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

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)

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.

Cervical Epidural Steroid Injection – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Evaluation, 10/25/10
- Cervical Spine MRI, M.D., 12/09/10
- Electrodiagnostic Studies, Unknown Provider, 01/12/11
- MRI Re-Read, M.D., 01/25/11, 05/03/11
- Re-Evaluation, Dr. 02/10/11, 03/09/11, 05/06/11
- Evaluation, M.D., 03/02/11, 03/28/11, 04/06/11
- Diagnostic Interpretation, Dr. 03/02/11, 03/28/11
- Left Shoulder X-Rays, M.D., 03/07/11
- Left Shoulder MRI, M.D., 03/07/11
- Utilization Review Referral, Dr. 03/28/11, 04/08/11
- Denial Letters, 04/04/11, 04/27/11
- Independent Medical Examination (IME), M.D., 05/05/11
- Correspondence, 05/24/11
- The ODG Guidelines were not provided by the carrier or the URA.
-

PATIENT CLINICAL HISTORY (SUMMARY):

The patient indicated she tripped and fell backwards, over a crate, landing on her back and striking her head. She complained of headaches, neck, back and right forearm pain. She was initially treated with physical therapy. Electrodiagnostic studies showed no evidence of a left C5 and C6 radiculopathy. An MRI of the cervical spine showed no

disc protrusions. There was low lumbar facet arthrosis. She was referred to an orthopedist, who recommended a cervical epidural steroid injection (ESI). A cervical MRI on 03/02/11 showed a disc herniation at C5-C6 measuring 5 mm. An MRI of the left shoulder showed evidence of sprain and stretching of the inferior AC joint ligament/capsule with somewhat prominent fluid in the AC joint itself. There was evidence of a partial thickness undersurface tear of the distal supraspinatus tendon. An Independent Medical Examination (IME) revealed that the claimant was not a candidate for a cervical ESI, due to absence of definable cervical radiculopathy on the left side.

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

In agreement with the prior reviewers, this patient, on physical examination, does not have physical examination findings supporting the diagnosis of a radiculopathy. There is not a Spurling's test documented, and the patient's subjective complaints do not include a radicular complaint in a dermatomal pattern that would support radiculopathy. Therefore, in line with ODG criteria that states an epidural injection is indicated if there is a radiculopathy documented by physical examination or corroborated by imaging studies, at this time, there is not a physical examination finding or a subjective complaint supporting a diagnosis of radiculopathy. Therefore, I do not find that the cervical epidural injection is not medically reasonable or necessary.

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)
- AMA GUIDES 5TH EDITION