

# US Decisions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Feb/16/2012

**IRO CASE #:**

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

Left C4-5 and C5-6 transforaminal epidural steroid injection (CPT codes 64479, 64480 and 77003-26)

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

M.D., Board Certified Anesthesiology

**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**

Official Disability Guidelines  
Cover sheet and working documents  
Utilization review determination dated 01/16/12, 02/08/12  
Preauthorization review dated 01/13/12, 02/08/12, 08/19/11  
Office visit note dated 01/09/12, 02/13/12, 01/16/12, 10/31/11, 09/19/11, 07/25/11, 06/06/11, 05/02/11, 03/28/11, 03/14/11, 02/21/11, 12/27/10, 11/15/10, 10/04/10, 07/26/10, 06/24/10, 06/07/10, 05/18/10, 04/26/10, 02/08/10  
CT cervical spine dated 09/26/07, 08/18/03  
Radiographic report dated 02/16/09, 03/07/07, 08/18/05, 09/25/06  
Procedure list no date  
Operative report dated 05/11/10, 05/25/09, 03/10/09, 10/23/07, 05/01/07, 01/09/07, 11/07/06, 08/29/06, 06/06/06, , 04/25/06, 03/07/06, 01/17/06  
MRI cervical spine dated 01/19/01

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. MRI of the cervical spine dated 01/19/01 revealed spondylitic changes at C4 through C7 with evidence of disc disease; small central disc herniation at C5-6. Treatment to date includes left CF on 12/21/04, right CF on 12/28/04, bilateral RFTC L3-S1 on 03/01/05, left CF on 01/17/06, left RFTC C3-C7 on 04/25/06, transforaminal epidural steroid injection left C5-6 and C6-7 on 06/06/06, spinal cord stimulator revision on 08/29/06 and replacement on 11/07/06, cervical epidural steroid injection on 01/09/07, cervical epidural steroid injection on 10/23/07, revision spinal cord stimulator on 03/10/09, transforaminal CESI C4-5 and C5-6 on 08/25/09 and revision spinal cord stimulator on 05/11/10. Note dated 10/31/11 indicates that the patient continues to complain of localized neck pain and denies any radiating arm pain or numbness and tingling. On physical examination cervical range of motion is restricted. Motor strength is 5/5 and sensation is intact; however, there is paresthesias over the left C5 dermatomal distribution. Deep tendon reflexes are 2+ bilaterally and symmetrically. Note dated 01/09/12 indicates

that physical examination is unchanged. Note dated 01/16/12 indicates that there is a sensory deficit noted over the left C5 and C6 dermatomal distribution with paresthesias. The most recent note dated 02/13/12 states that "sensory examination of the C5, C6, C7, C8 and T1 dermatomal distribution shows no sensory deficit".

Initial request for left C4-5 and C5-6 epidural steroid injection was non-certified on 01/16/12 noting that there are no specific examination findings of a neurologic deficit from deep tendon reflex loss, motor loss and only reports of paresthesias to support a radiculopathy. There is no support from imaging. The denial was upheld on appeal dated 02/08/12 noting that in this patient's case, there are subjective complaints of paresthesias; however, there are no examination findings of a neurologic deficit. There is no corroboration from the imaging and there are no electrodiagnostic test findings to support a radiculopathy. In addition, there is no evidence of recent conservative treatment.

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

Based on the clinical information provided, the request for left C4-5 and C5-6 transforaminal epidural steroid injection (CPT codes 64479, 64480 and 77003-26) is not recommended as medically necessary, and the two previous denials are upheld. The patient's physical examination fails to establish the presence of active cervical radiculopathy, as required by the Official Disability Guidelines. There are no sensory or motor deficits, and deep tendon reflexes are 2+ bilaterally and symmetrically. There are no recent imaging reports or electrodiagnostic findings provided to support a diagnosis of radiculopathy. There is no indication that the patient has undergone any recent active treatment. Given the current clinical data, the reviewer finds the requested Left C4-5 and C5-6 transforaminal epidural steroid injection (CPT codes 64479, 64480 and 77003-26) is not indicated as medically necessary.

**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)