

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: February 14, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

62310 cervical epidural steroid injection #2 @ C7-T1, 72275 epidurography, 77003 fluoroguide.

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

M.D., Board Certified in Neurology.

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)

The requested service, 62310 cervical epidural steroid injection #2 @ C7-T1, 72275 epidurography, 77003 fluoroguide, is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 1/24/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 1/25/12.
3. Notice of Assignment of Independent Review Organization dated 1/26/12.
4. Denial documentation.
5. Letter from MD dated 1/03/12.
6. Medical records from MD dated 4/11/11, 5/23/11, 6/03/11, 7/15/11, 10/11/11, 11/08/11, and 12/20/11.
7. Procedure note from Institute of Pain Management dated 7/01/11.
8. MRI of the cervical spine dated 9/24/08 and 12/16/09.
9. EMG report dated 10/19/06.
10. Cervical range of motion test dated 10/19/05.
11. Left upper extremity impairment evaluation report dated 10/19/05.
12. Right upper extremity impairment evaluation report dated 10/19/05.
13. Independent Review Organization Summary dated 1/30/12.
14. TDI Division of Work Comp Status Report dated 9/14/05.
15. Texas Workers' Compensation Work Status Report dated 9/29/05 through 12/14/11.
16. Medical records from Back & Neck Pain Center dated 9/29/05 through 11/17/05.
17. Laboratory results dated 11/17/05.
18. Physical Therapy Evaluation Summary dated 2/22/06 through 4/20/06.
19. Prescription and Certification of Medical Necessity dated 2/27/06.
20. Medical records from MD dated 2/23/06 through 5/04/06.
21. Physical Therapy Progress Note dated 3/09/06 through 5/04/06.
22. Report of Medical Evaluation dated 3/20/08.
23. Report from MD dated 3/20/08.
24. Spine Institute medical records dated 4/17/08.
25. Specialty Group, PA medical records dated 4/16/08 through 8/10/10.
26. Medical records from MD dated 4/25/06 through 1/25/11.
27. MRI of the left shoulder dated 9/24/08.
28. MRI of the right shoulder dated 11/05/08.
29. Medical records from DO dated 11/26/08 through 3/19/09.
30. Medical records from MD dated 3/19/09 through 3/31/09.
31. Medical records from, MD dated 10/27/09.
32. Upper Extremity Electrodiagnostic Study dated 1/29/10.
33. Medical records from MD dated 2/17/10.
34. Medical records from DO dated 3/22/10 through 4/20/10.
35. Undated letter from DC.
36. Unsigned medical records dated 10/25/10.
37. Drug Screen Result Form dated 12/14/10.

38. Healthcare & Rehabilitation medical records dated 3/30/11 through 12/15/11.
39. Medical records from MD dated 4/20/11.
40. Medical records from unknown source dated 4/22/11 through 12/15/11.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury on xx/xx/xx. On 7/01/11, the patient underwent cervical epidural steroid injection at C7-T1 and epidurogram. The patient's postoperative diagnoses included chronic neck pain, cervical disc displacement, and cervical radiculopathy. On 11/08/11, the medical records noted that the patient had improved since her prior visit. The patient's medications included Ultram, citalopram and Zanaflex. The documentation noted good results with interventional management. On 10/11/11, the medical records noted a worsening condition. The provider noted that the patient had failed conservative care, physical therapy, nonsteroidal anti-inflammatory medications, muscle relaxants and a home exercise program. Coverage for 62310 cervical epidural steroid injection #2 @ C7-T1, 72275 epidurography, 77003 fluoroguide has been requested.

The URA indicates that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the initial denial stated that the ODG allows up to two cervical epidural injections during the treatment phase of an acute cervical radiculopathy and recommends no interventional management in the chronic pain phase. The URA noted that the patient has had at least two previous cervical epidural steroid injections, and the ODG recommends more than two epidural injections only in unusual circumstances. Per the URA, this case does not meet that threshold, as there has been no significant change in findings or any intervening injury. On appeal, the URA noted that the requested services offer no significant long-term functional benefit.

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

Per ODG criteria, cervical epidural steroid injections are recommended as an option for treatment of radicular pain. Radicular pain is defined as pain in dermatomal distribution with corroborative findings of radiculopathy. The ODG criteria note that radiculopathy must be documented by physical examination and corroborated by electrodiagnostic testing and/or imaging studies. This patient has neck pain and shoulder pain. Per the submitted documentation, the patient does not have pain in a dermatomal distribution. There is no documentation of segmental weakness, reflex asymmetry, or dermatomal sensory deficit. There is a lack of clinical findings to support the diagnosis of cervical radiculopathy. Thus, cervical epidural steroid injections are not consistent with ODG criteria in this clinical situation. All told, 62310 cervical epidural steroid injection #2 @ C7-T1, 72275 epidurography, 77003 fluoroguide is not medically necessary in this patient's case.

Therefore, I have determined the requested 62310 cervical epidural steroid injection #2 @ C7-T1, 72275 epidurography, 77003 fluoroguide is not medically necessary for treatment of the patient's medical condition.

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)