



Notice of Independent Review Decision

**DATE OF REVIEW:** 05/30/12

**IRO CASE #:**

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

One cervical epidural steroid injection under fluoroscopy

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., board certified in Neurology with Added Qualifications in Pain Management, fellowship trained in Pain Medicine

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

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

**INFORMATION PROVIDED FOR REVIEW:**

1. Certification of independence of the reviewer and TDI case assignment
2. TDI case assignment
3. Letters of denial, 04/10/12 and 05/07/12, including criteria used in the denial
4. MRI scan of the cervical spine report
5. Operative report for trigger point injections with sedation, 04/14/11
6. Treating doctor's evaluations and follow-up examinations dated 02/17/11 through 04/03/12

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
723.1	62310		Prosp.		04/10/12 –				Upheld

**1908 Spring Hollow Path  
 Round Rock, TX 78681  
 Phone: 512.218.1114  
 Fax: 512.287-4024**

					05/07/12				
723.1	77003		Prosp.		04/10/12 – 05/07/12				Upheld
723.1	72275		Prosp.		04/10/12 – 05/07/12				Upheld
723.1	99144		Prosp.		04/10/12 – 05/07/12				Upheld
723.1	99145		Prosp.		04/10/12 – 05/07/12				Upheld
723.1	A4550		Prosp.		04/10/12 – 05/07/12				Upheld
723.1	A4649		Prosp.		04/10/12 – 05/07/12				Upheld

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The claimant sustained a work-related injury on xx/xx/xx. The claimant is now a female who recently developed some possible paresthesias in the upper extremities as noted on a clinical note in April 2012 by Dr.. Prior to that, notes indicate pain complaints to be primarily axial and were being treated by trigger point injections. Because of the upper extremity symptoms, Dr. decided to proceed with an updated MRI scan of the cervical spine, which was completed and showed no significant abnormalities other than mild spondylosis. Specifically, there was no evidence of spinal canal stenosis or foraminal stenosis at any level. EMG studies were also described in the April progress note, but it is unclear whether these were completed. A cervical epidural steroid injection was then suggested due to the “radicular” symptoms.

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

I agree with previous reviewers that there is no significant evidence currently of radiculitis that would warrant treatment with cervical epidural steroid injections. There is no significant physical finding other than some sensory disturbance that is not isolated to only a single dermatome, but is spread over a total of three nerve root levels in the upper extremities. There is no true weakness reported with some reduction in grip strength described as “give way” secondary to pain. I agree with previous reviewers that there is not sufficient evidence currently to justify proceeding with a cervical epidural steroid injection, and that the request does not conform to ODG criteria.

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

\_\_\_\_\_ ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.

# INDEPENDENT REVIEW INCORPORATED

---

- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)