



Notice of Independent Review Decision

**DATE OF REVIEW:** 06/05/12

**IRO CASE #:**

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

Cervical epidural steroid injection number two

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in private practice of Pain Management full time since 1993

**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)

<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>
HNP L5-6	62310		Prosp						Overturn
HNP L5-6	77003		Prosp						Overturn
HNP L5-6	72275		Prosp						Overturn
HNP L5-6	6226		Prosp						Overturn

*(Note: Diagnostic code and codes of services being denied obtained from Zurich Services Corp. documented provided dated 04/16/12.)*

**INFORMATION PROVIDED FOR REVIEW:**

1. TDI case assignment.
2. Letters of denial 04/19/12 & 05/08/12, including criteria used in the denial.
3. Correspondence from to IRI, 05/24/12.
4. Various additional articles and publications regarding the use of ESI.
5. Treating doctor's orthopedic reports 04/09/12 & 04/25/12.
6. MRI cervical spine 05/18/11, and cervical epidural steroid injection report 09/19/11.
7. Cervical x-ray 04/09/12.
8. EMG-NCS 10/14/11 (amended report).

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

This female was injured on xx/xx/xx and has neck pain that radiates to the right upper extremity along with paresthesias, weakness, and hyporeflexia. MRI scan shows herniation at C5/C6. Electrodiagnostic studies show a right C6, possibly C8/T1 radiculopathy. A cervical epidural steroid injection on 09/15/11 on 09/19/11 provided 70% pain relief.

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

ODG require evidence of radiculopathy with corresponding abnormality on MRI scan. There is electrodiagnostic and physical exam evidence of radiculopathy on the right at C6 with corroborating abnormality on the MRI scan at C5/C6. It is reasonable to perform an epidural steroid injection. For a repeat ESI, there should be at least 50% pain relief for eight weeks. There is documentation that the patient has 70% pain relief that is persisting. ODG are met for the requested cervical epidural steroid injection number two.

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

*(Check any of the following that were used in the course of your review.)*

- 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.

# INDEPENDENT REVIEW INCORPORATED

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- \_\_\_\_\_ 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.)