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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:** MAY 17, 2012

**IRO CASE #:**

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

Outpatient Cervical ESI Right at C5-6 (62318, 62281, 62310, 62284, 72275, 99144).

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

M.D., Board Certified in Neurological 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)

The requested service, Outpatient Cervical ESI Right at C5-6 (62318, 62281, 62310, 62284, 72275, 99144), 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 4/25/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 4/27/12.
3. Notice of Assignment of Independent Review Organization dated 4/27/12.
4. Center for Pain Management progress notes dated 4/4/12, 2/27/12, and 1/25/12.
5. Letter from MD dated 3/26/12.
6. Surgery Center operative report dated 8/30/11.
7. Clinic notes from MD dated 3/19/12.
8. MRI of the Cervical Spine without Contrast report dated 3/27/12.
9. Utilization Review Referral dated 3/7/12.
10. Denial documentation dated 4/20/12 and 3/12/12.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who sustained an injury on xx/xx/xx. A procedure report dated 8/30/11 reported the patient underwent a right stellate ganglion block. A clinical note dated 1/25/12 reported the patient had 100% relief for several weeks from 2 prior stellate ganglion blocks and subsequent 60% overall pain reduction. The note reported that the patient continued to perform physical therapy at home. The patient complained of 7-8 of 10 on the pain scale. On physical examination, there was tenderness to palpation of the right shoulder with swelling, allodynia, mottling, discoloration, coldness to palpation, and guarding. The note reported that the patient was recommended for a C5-6 epidural steroid injection on the right side to allow for more longevity of overall pain control. Follow-up on 2/27/12 reported the patient continued to complain of right shoulder pain with some progression of neurological deficits. The patient was recommended for MRI of the cervical spine. Prior review dated 3/12/12 reported that the request for cervical epidural steroid injection was denied due to lack of imaging and electrodiagnostic studies confirming pathology at the treatment level as well as lack of physical exam findings. Clinical note dated 3/19/12 reported the patient had electrodiagnostic study confirming right C6 and right C7 radiculopathy. The patient was again recommended for a MRI and injection.

A letter dated 3/26/12 reported the patient had not responded to conservative measures and would benefit from an epidural injection. MRI of the cervical spine without contrast dated 3/27/12 revealed findings of disc bulge at C2 to C5. The patient had a broad-based protruding disc at C5-6 with posterolateral bone spurs, facet arthrosis, moderate spinal stenosis, and moderate to severe bilateral foraminal narrowing. The patient also had broad-based disc protrusion at C6-7 with severe foraminal narrowing on the left, moderate foraminal narrowing on the right and moderate spinal stenosis. Clinical note dated 4/4/12 reported that the patient had hyperreflexia in the upper and lower extremities with muscle wasting in the upper extremities.

The patient was recommended for epidural steroid injection at C5-6 on the right. The request for an epidural steroid injection was denied by the URA due to lack of significant physical exam findings.

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

The request for outpatient cervical epidural steroid injection (ESI) on the right at C5-6 is not consistent with Official Disability Guidelines (ODG). The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. This patient has a history of right shoulder symptoms that have responded favorably to two stellate ganglion blocks. The most recent physical exam findings continue to suggest complex regional pain syndrome of the right upper extremity. The updated note submitted for review did include the MRI revealing disc bulging at C5-6 and C6-7. However, there continues to be a lack of physical exam findings consistent with cervical radiculopathy at the C5-6 level. Official Disability Guidelines recommend that there be physical exam findings consistent with radiculopathy corroborated by imaging and/or electrodiagnostic studies prior to epidural steroid injections. Given the lack of neurological deficits on physical examination, the request for cervical epidural steroid injection is not supported. Therefore, I have determined the requested Outpatient Cervical ESI Right at C5-6 (62318, 62281, 62310, 62284, 72275, 99144) is not medically necessary for treatment of the patient's medical condition.

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**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)**