

# Applied Assessments LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Aug/28/2013

### IRO CASE #:

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

Reconsideration for ESI, C8

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

Board Certified Orthopedic Surgeon

### 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical notes dated 10/17/12 – 06/20/13

Electrodiagnostic studies dated 03/28/13

Previous utilization reviews dated 07/16/13 & 08/02/13

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his cervical region. The MRI of the cervical spine dated 10/17/12 revealed mild degenerative disc disease noted at C7-T1. The clinical note dated 01/31/13 details the patient complaining of radiating pain from the neck into the 4th and 5th digits of the left hand. The patient also reported weakness in the left upper extremity. The patient's past medical history is significant for a cervical fusion in September of 2010. The note does detail the patient utilizing Hydrocodone and Lyrica for pain relief. Strength deficits were noted in the left biceps and wrist. Decreased sensation was noted in the C6, C7, and C8 distributions. The clinical note dated 03/28/13 details the patient continuing with radiating pain from the neck into the left upper extremity specifically in the C8 distribution. The electrodiagnostic studies completed on 03/28/13 revealed essentially normal findings. The clinical note dated 06/20/13 details the patient continuing with radiating pain into the left upper extremity.

The previous utilization review dated 07/16/13 resulted in a denial for a C8 epidural steroid injection as no confirmation was submitted regarding the patient's radiculopathy component. The MRI revealed no significant neurocompressive findings. The EMG study failed to

demonstrate any cervical radiculopathy.

The previous utilization review dated 08/02/13 for an epidural steroid injection at C8 resulted in a denial as no electrodiagnostic evidence existed regarding the patient's radiculopathy confirmation. Additionally, the MRI failed to reveal any significant neurocompressive findings.

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

The documentation submitted for review elaborates the patient complaining of radiating pain from the cervical region into the left upper extremity. An epidural steroid injection would be indicated in the cervical region provided the patient meets specific criteria to include imaging studies confirm the patient's neurocompressive findings or electrodiagnostic studies revealed evidence of a radiculopathy component. No information was submitted regarding the patient's confirmation of neurocompressive findings or a radiculopathy component. Given that no information was submitted confirming the patient's radiculopathy component, this request is not indicated. As such, it is the opinion of the reviewer that the request for an epidural steroid injection at C8 is not recommended 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)