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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/17/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Right C7 epidural steroid injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O. Board Certified Physical Medicine and Rehabilitation and Pain Medicine

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. It is the opinion of the reviewer that the request for right C7 epidural steroid injection is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 05/31/13, 05/17/13

Appeal letter dated 05/14/13

Electrodiagnostic consultation dated 06/25/12, 01/30/12

Encounter summary dated 04/29/13, 04/24/13, 04/22/13, 03/18/13, 02/14/13, 01/14/13

Follow up note dated 11/26/12

Handwritten note dated 05/02/13, 02/14/13

Operative report dated 09/21/12

MRI right shoulder dated 12/19/11

MRI cervical spine dated 01/08/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. Electrodiagnostic consultation dated 01/30/12 revealed no evidence of right cervical radiculopathy. Electrodiagnostic consultation dated 06/25/12 is reported as a normal study. The patient underwent right shoulder arthroscopic rotator cuff repair on 09/21/12. MRI of the cervical spine dated 01/08/13 revealed at C6-7 normal sagittal plane alignment with disc space narrowing and broad based annular bulging (4 mm) with mild canal stenosis; no significant foraminal stenosis. At C7-T1 there is no disc herniation and no significant canal or foraminal stenosis. Note dated 03/18/13 indicates that trigger point injection did seem to help with symptoms in the right periscapular region. Note dated 04/29/13 indicates that he reports 50% improvement from the cervical epidural steroid injection.

Initial request for right C7 epidural steroid injection was non-certified noting that MRI showed no significant radicular findings so its result does not meet ODG criteria. EMG/NCV specifically showed no radiculopathy so its result does not meet ODG criteria either for an

epidural steroid injection. Appeal letter dated 05/14/13 indicates that on physical examination the patient does have radicular findings with a Spurling's finding, as well as reduced C7 sensation. EMG did not show active radiculopathy; however, EMG is not 100% and it is not perfect. The denial was upheld on appeal dated 05/31/13 noting that there was no indication of a specific objective cervical radiculopathy occurring at the right C7 level based on the physical examination findings and workup done to support the need for the epidural steroid injection. Also previous electrodiagnostic testing was normal and did not reveal a radiculopathy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on xx/xx/xx. Electrodiagnostic consultations dated 01/30/12 and 06/25/12 do not reveal any evidence of cervical radiculopathy. The submitted cervical MRI does not document any significant neurocompressive pathology. The Official Disability Guidelines require radicular findings on physical examination corroborated by imaging studies and/or electrodiagnostic results. Additionally, the submitted records indicate that the patient underwent previous cervical epidural steroid injection; however, the records fail to document at least 50% pain relief for at least 6 weeks, as required by the Official Disability Guidelines prior to the performance of repeat epidural steroid injection. As such, it is the opinion of the reviewer that the request for right C7 epidural steroid injection 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)