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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/18/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: cervical epidural steroid injection @ C3-4, C4-5 using fluoroscopy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., 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. It is the opinion of the reviewer that the request for cervical epidural steroid injection @ C3-4, C4-5 using fluoroscopy is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 05/13/13, 06/21/13
Office note dated 04/29/13
EMG/NCV dated 04/11/13
MRI cervical spine dated 03/22/13
Reference material
Initial evaluation report dated 02/01/13
Visit note dated 06/06/13
MRI lumbar spine dated 03/22/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. On this date the patient was running and going down the stairway when she tripped and fell down the stairway. MRI of the cervical spine dated 03/22/13 revealed at C3-4 there is a 1.5 mm central disc bulge; no significant canal or foraminal stenosis. At C4-5 there is a 2.5 mm central disc protrusion abutting the cervical cord anteriorly. EMG/NCV dated 04/11/13 revealed electrodiagnostic evidence of C6-7 nerve root irritation on the left. Note dated 04/29/13 indicates that the patient is still doing therapy which has provided relief to her right shoulder and right ankle. On physical examination strength is rated as 5/5 throughout the upper extremities. Deep tendon reflexes are 2/4 in bilateral biceps and 1/4 bilateral triceps. Reflexes are normal and sensation is intact. Spurling's test is positive on the left.

Initial request for cervical epidural steroid injection C3-4, C4-5 using fluoroscopy was non-certified on 05/13/13 noting that MRI showed no cord pressure and only narrowing of the C5-7 neuroforamen. The electrodiagnostic study was apparently only interpreted. There were only mild abnormality reported the paraspinal muscles. The clinical examination on 04/29/13

was normal for reflexes, motor and sensation in the upper extremities. The denial was upheld on appeal dated 06/21/13 noting that the objective physical examination findings do not clearly document a cervical radiculopathy at the C3-4 or C4-5 level to support the epidural steroid injection. An epidural steroid injection at multiple levels, if it is done interlaminarly, is not supported and only a single interlaminar injection is supported. The treating provider's request exceeds this; therefore, the request cannot be certified. It should also be noted that there is no significant neurocompression documented on the MRI study of the cervical spine.

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. The submitted EMG/NCV noted electrodiagnostic evidence of C6-7 nerve root irritation; however, the requested epidural steroid injection is for levels C3-4 and C4-5. The patient's cervical MRI does not document any significant neurocompressive pathology. The patient's physical examination documents normal sensation, deep tendon reflexes and motor strength in the bilateral upper extremities. The Official Disability Guidelines require radicular findings on physical examination corroborated by imaging studies and/or electrodiagnostic testing. As such, it is the opinion of the reviewer that the request for cervical epidural steroid injection @ C3-4, C4-5 using fluoroscopy 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)