

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/29/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: cervical ESI at C3-4

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Anesthesiology 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 this reviewer that the request for a cervical ESI at C3-4 is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his cervical region. The MRI of the cervical spine dated 02/14/13 revealed an unremarkable cervical spine. Minor degenerative changes were identified at C3-4. The operative note dated 12/03/13 indicates the patient undergoing a bilateral suboccipital nerve block. The clinical note dated 03/17/14 indicates the patient utilizing Naprosyn, Gabapentin, and Norco for pain relief. Upon exam, tenderness was identified upon palpation throughout the cervical spine. The patient also reported neck pain with radiating pain into the upper extremities. Severe headaches were also identified associated with the neck pain. The clinical note dated 04/10/14 indicates the patient continuing with complaints of neck pain radiating into the upper extremities. There is an indication the patient has exhausted all conservative treatments. The clinical note dated 05/12/14 indicates the patient rating the neck pain as 8/10. There is an indication the patient has radiculopathy that follows the C3-4 and C4-5 dermatomal distributions. Abnormal reflexes and sensation were identified. Abnormal strength was also revealed. Severe range of motion deficits were identified secondary to pain.

The utilization review dated 05/01/14 resulted in a denial as no radiculopathy was identified in the appropriate distributions.

The utilization review dated 05/19/14 resulted in a denial as vague findings were submitted with the documentation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of cervical region pain. An epidural steroid injection would be indicated in the cervical region provided the patient meets specific criteria to include findings consistent with radiculopathy identified in the appropriate distributions and the imaging studies confirm the patient's neurocompressive findings. Non-specific findings were identified in the clinical

notes in regards to the patient's sensation, reflex, and strength deficits. No information was submitted regarding any information at a specific distribution. Additionally, the submitted MRI revealed very minimal findings at the C3-4 level. Given these factors, the request is not indicated. As such, it is the opinion of this reviewer that the request for a cervical ESI at C3-4 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)