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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 4/21/14

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a cervical epidural steroid injection at C3/4 under fluoroscopy with possible monitored anesthesia.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

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 reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a cervical epidural steroid injection at C3/4 under fluoroscopy with possible monitored anesthesia.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant was involved in an accident on xx/xx/xx and reported left shoulder arm and neck pain following that event. He did have a left biceps tear with repair done on 5/1/2009. He was placed at MMI on 10/14/2009 with 1% IR. MRI of the cervical spine on 10/31/2012 indicates C3/4 narrowed disc height. note from 1/24/2014 indicates there is right sided neck pain radiating to the right trapezius and left elbow. He reports the claimant had post op therapy from following the biceps tendon repair. There was not therapy offered for the neck at that time.

His medications include Lyrica, hydrocodone and Naproxen. There is a request for cervical ESI.

Although the patient does complain of radiating neck pain there are no specific objective findings such as sensory deficits or provocative tests to support diagnosis of C3/4 radiculopathy. There is evidence of disc bulge and facet involvement on cervical MRI. There is no evidence that non-surgical treatment modalities have been offered for this recurrence of neck pain prior to an ESI.

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

A cervical ESI is not indicated as this claimant has not had conservative treatment for his chronic neck pain other than medication management. There is no report of a home exercise program. The claimant continues to work. There is not clear evidence of radiculopathy. There for ESI per the ODG guidelines is not supported.

ODG Neck and upper back guidelines recommends ESI as an option for treatment of radicular pain to reduce pain and inflammation thereby facilitating progress in more active treatment programs and avoiding surgery. This treatment alone offers no significant long term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The pain should be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

In the pain chapter regarding ESIs, there is no evidence based literature to make a firm recommendation as to sedation during an ESI. The use of sedation introduces some potential diagnostic and safety issues, making unnecessary use less than ideal. Therefore, the requested procedure is not medically necessary at this time.

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)