

DATE: 03/31/15

Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 03.31.15

IRO CASE #:

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

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in practice of Pain Management full time for over 20 years

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical epidural steroid injection at C6 with intravenous sedation

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- X** Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
847.0	62310 77003		Prosp.		02-19-15				Upheld

PATIENT CLINICAL HISTORY (SUMMARY):

This female sustained a work-related injury on xx/xx/xx when she was involved in an altercation. There is persistent neck and left arm pain. Physical therapy and medications have been utilized. The MRI on 05/24/14 was reported to show disc bulging at C5-C6 and C6-C7 without impingement. On 09/09/14, a cervical epidural steroid injection at C5-C6 and C6-C7 were performed. An EMG was reported to be normal. At the office visit on 12/03/13, described 70 percent pain relief from the epidural steroid injection and increased functionality. No neurological deficit was described at this visit. On the 01/22/15 office visit, described a recurrence of symptoms and no neurological deficit was described.

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

The Official Disability Guidelines for cervical epidural steroid injection include failure of conservative measures, evidence of radiculopathy, and corroborating findings on MRI. There has been failure of conservative measures, but no clinical evidence of radiculopathy is present and the EMG studies were normal. The MRI does not show impingement. The Official Disability Guidelines are not met for the requested procedure.

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 judgment, clinical experience and expertise in accordance with accepted medical Standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Office 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)