



**Notice of Independent Review Decision - WC**

**DATE OF REVIEW:** 08/13/15

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Cervical Epidural Steroid Injections at C7/T1 level using Fluoroscopic Guidance to include CPT codes 62310 and 77003

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

Board Certified in Physical Medicine and Rehabilitation

**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 or not medical necessity exists for each of the health care services in dispute:**

- Cervical Epidural Steroid Injections at C7/T1 level using Fluoroscopic Guidance to include CPT codes 62310 and 77003 - Upheld

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The records available for review indicate that the date of injury is listed as xx/xx/xx. It is documented that on the date of injury the claimant was driving. The claimant suddenly moved the cervical region and the claimant developed symptoms of cervical pain. Additionally, there were symptoms of left shoulder pain.

It is documented that the claimant was evaluated on 10/03/14. On this date, there were symptoms of left shoulder pain and pain throughout the left upper extremity. The claimant was diagnosed with a shoulder strain and radiculitis.

The claimant was re-evaluated on 10/06/14. On this date, there were symptoms of left shoulder pain described as a 7/10 on a scale of 1 to 10. It was recommended that the claimant receive an evaluation with an orthopedic physician.

On 10/09/14, the claimant was evaluated. On this date, the claimant was diagnosed with what was described as rotator cuff irritation. The claimant received a therapeutic injection to the symptomatic shoulder on this date.

The claimant was evaluated on 10/10/14. On this date, the claimant was diagnosed with a left shoulder strain.

re-evaluated the claimant on 10/17/14. On that date, there were symptoms of pain described as an 8/10 on a scale of 1 to 10. It was recommended that the claimant receive access to treatment in the form of physical therapy services. It was documented that there were signs and symptoms consistent with a cervical radiculopathy.

On 10/27/14, the claimant was evaluated. On this date, it was documented that plain x-rays of the cervical spine revealed findings consistent with loss of the cervical lordotic curve with spondylitic changes. It was recommended that a cervical MRI scan be obtained.

A cervical MRI scan was obtained on 10/30/14. The study revealed findings consistent with the presence of minimal central canal stenosis and mild bilateral neural foraminal stenosis at the C4-C5 level.

The claimant was re-evaluated on 11/03/14. It was documented that utilization of prescription medications, which did include a Medrol Dosepak, did not decrease pain symptoms. It was recommended that the claimant receive access to treatment in the form of physical therapy services, and consideration was to be given for a cervical epidural steroid injection.

The claimant was evaluated on 11/07/14. On this date, the claimant was provided a prescription for Zanaflex, as well as Norco.

The claimant was evaluated on 11/19/14. It was recommended that the claimant be maintained on an off-work status. It was recommended that the claimant continue to receive access to treatment in the form of physical therapy services.

On 12/17/14, the claimant was re-evaluated. It was recommended that treatment be considered in the form of a left transforaminal C6-C7 epidural steroid injection.

On 01/16/15, the claimant was evaluated. A recommendation was made for treatment in the form of a left transforaminal C6-C7 epidural steroid injection.

evaluated the claimant on 01/27/15. On this date, it was documented that the claimant was to be released from the care, as there was not compliance with respect to narcotic prescription utilization with this physician.

On 02/05/15, evaluated the claimant. On this date, it was again recommended that consideration be given for treatment in the form of a therapeutic injection to the cervical region.

On 02/20/15, evaluated the claimant. It was documented that the claimant was driving up to five hours per day in the work place.

On 03/06/15, the claimant received an evaluation. It was documented that the claimant was driving up to eight hours per day in the work place.

Cervical spine x-rays obtained on 03/16/15 were described as negative for an acute osseous abnormality of the cervical spine.

On 05/27/15, evaluated the claimant. Subjectively, there were symptoms of cervical pain with symptoms of weakness in the upper extremities. It was recommended that a cervical MRI scan be accomplished.

The claimant was evaluated on 06/04/15. On this date, it was documented that past treatment in the form of physical therapy did not decrease pain symptoms. There were symptoms of posterior cervical pain. Objectively, there was documentation of normal reflexes and normal motor as well as sensory function on physical examination.

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

Based upon the records available for review, Official Disability Guidelines would not support a medical necessity for the requested treatment in the form of a cervical epidural steroid injection. Currently, this reference does not support a medical necessity for a cervical epidural steroid injection as a routine procedure to be provided as it relates to management of the medical condition of a cervical radiculopathy. At this time, in this case, this reference would not support this request to be one of medical necessity, as a past cervical MRI scan did not reveal the presence of any findings worrisome for a compressive lesion upon a neural element in the cervical spine. With such documentation, the above-noted reference would not support a medical necessity for this requested procedure.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**