

# Core 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Feb/03/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** left C6-C7 transforaminal epidural steroid injection with fluoroscopy and monitored anesthesia care

**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 this reviewer's opinion that medical necessity for left C6-C7 transforaminal epidural steroid injection with fluoroscopy and monitored anesthesia care is not established at this time

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who was injured on xx/xx/xx and has been followed for complaints of bilateral neck pain radiating to the left upper extremity after pulling an object. The patient was initially treated with anti-inflammatories, muscle relaxers, as well as cortical steroids. Other medications included anti-convulsants, anti-depressants, and Clonazepam. There was no discussion regarding prior physical therapy. MRI studies of the cervical spine from 10/14/14 were almost impossible to review due to poor copy quality. The impression could not be read. The patient was seen on 12/08/14 with continuing complaints of neck pain radiating to the upper extremities. The patient indicated his neck pain was worse than his upper extremity symptoms. The patient's physical exam noted no sensory loss or motor weakness in the upper extremities. Reflexes were noted to be trace to absent at the left triceps and brachioradialis as compared to the right side. There was no evidence of clonus. Range of motion was normal in the cervical region. The requested epidural steroid injection to the left at C6-7 with monitored anesthesia care and fluoroscopy was denied by utilization review on 12/24/14 and 01/08/15. There was no evidence of reproducible radicular symptoms or physical exam findings and MRI findings did not correlate with physical exam findings.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has been followed for complaints of pain in the cervical region radiating to the upper extremities. The patient's physical exam findings did note reflex changes in the left upper extremity as compared to the right side without motor weakness or sensory deficits. This reviewer was unable to discern specific findings on the provided MRI study due to very poor copy quality. It was unclear to what extent there was nerve compressive findings at C6-7 that would have supported epidural steroid injections as outlined by current evidence-based guidelines. Furthermore, the clinical documentation did not discuss prior physical therapy which is a recommended modality before consideration of injection therapy. The clinical documentation submitted for review also did not discuss any needle phobia or procedural anxiety that would support the use of monitored anesthesia care as this is not recommended by guidelines. As the clinical documentation submitted for review does not meet guideline recommendations regarding the proposed services, it is this reviewer's opinion that medical necessity for left C6-C7 transforaminal epidural steroid injection with fluoroscopy and monitored anesthesia care is not established at this time and the prior denials are upheld.

**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)