

# Pure Resolutions LLC

An Independent Review Organization

Phone Number:  
(817) 779-3288

990 Hwy. 287 N. Suite 106 PMB 133  
Mansfield, TX 76063  
Email: [pureresolutions@irosolutions.com](mailto:pureresolutions@irosolutions.com)

Fax Number:  
(817) 385-9613

Case Number:

Date of Notice: 11/02/2015

## Review Outcome:

**A description of the qualifications for each physician or other health care provider who reviewed the decision:**

Anesthesiology

## Description of the service or services in dispute:

Cervical epidural steroid injection under flouroscopy with IV sedation, C4-5 level, outpatient

**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)

## Patient Clinical History (Summary)

Patient is a male. On xxxx, he was seen for initial pain consult. He had a complaint of chronic persistent right shoulder arm and hand pain associated with a shooting pain, increased sweat production, sensitivity to touch and involuntary spasms. He also reported ongoing headaches and mood instability associated with insomnia. He had sustained a severe concussion with neck pain and back pain that had occurred since that time. He also had suffered a fracture of his clavicle. On exam, he had mild allodynia to light touch and trigger points were noted. On xxxxx, a MRI of the cervical spine revealed at C4-5, there was minimal posterior osteophytic ridge/disc osteophyte complex, effacing the ventral subarachnoid space.

No central canal stenosis was seen. Mild right neural foraminal narrowing was suspected on the basis of unciniate hypertrophy. On xxxxx, the patient was seen in clinic. It was noted he had failed conservative rehab and he showed signs of radiculopathy including weakness, numbness and tingling in a C5 distribution on into his hand. He noted decreased pin prick sensation in a C5 distribution and the plan was for cervical epidural steroid injection.

**Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.**

On xxxxx, a utilization review report noted the request was not medically necessary. ODG was used as the citing reference, which recommends against the use of ESI in the cervical spine.

On xxxxx, a utilization review report noted the request was not supported as being medically necessary. ODG was used as the citing source, noting that this procedure is not recommended for the cervical spine.

ODG does stated that ESI in the cervical spine is not supported at this time. the records do not note a condition significant enough to consider this patient an outlier to the guidelines.

It is the opinion of this reviewer that the request for cervical epidural steroid injection under fluoroscopy with iv sedation, c4-5 level, outpatient, is not medically necessary 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 and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- 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-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical Literature (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)