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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: February 22, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical epidural steroid injection (62310, 77003, 99144).

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

M.D., Board Certified in Physical Medicine and Rehabilitation 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)

The requested cervical epidural steroid injection (62310, 77003, 99144) is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported a work-related injury on XX/XX/XX. Magnetic resonance imaging (MRI) of the cervical spine on XX/XX/XX revealed findings of C3-4 left uncinate spurring and mild anterolisthesis as well as C4-5 and C5-6 spondylosis with foraminal narrowing and mild central stenosis. The evaluation dated XX/XX/XX indicates that the patient complained of neck pain rated at a 7/10. Per report, the patient underwent electromyography (EMG) and nerve conduction studies on XX/XX/XX that were suggestive of left C6 versus C7 radiculopathy. She was willing to proceed with a cervical epidural steroid injection at the C6-7 and at the C7-T1. She had tried medications including hydrocodone, which she stated was effective. On physical examination, she had a positive Spurling's sign bilaterally and limited

range of motion. She was diagnosed with cervical radiculopathy and recommendations were made for a cervical epidural steroid injection.

The URA indicates that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. The denial letter indicates that the requested services are not medically necessary given the serious risks of this procedure in the cervical region, and the lack of quality evidence for sustained relief.

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

The requested cervical epidural steroid injection is not medically necessary for treatment of the patient's medical condition. Per literature recommendations, cervical epidural steroid injections are for patients who have radiculopathy by examination that is corroborated with imaging and/or electrodiagnostic testing after the failure of all recommended forms of conservative therapy. It is also stated that there is a lack of high quality studies supporting the effectiveness of cervical epidural steroid injections and there are high risks associated with performing injections in this region. The documentation submitted for review indicates that the patient has undergone electrodiagnostic studies that support findings of C6 versus C7 radiculopathy. However, no official electrodiagnostic studies were provided for review to confirm the patient does have findings of radiculopathy at the level of injection. Also, the patient's MRI studies do not support nerve root impingement at any specific level and do not support a diagnosis of radiculopathy. Additionally, the most recent physical examination did not reveal any neurological deficits, such as decreased sensation or motor strength in a specific dermatomal or myotomal distribution. Lastly, the Official Disability Guidelines do not support performing epidural steroid injections in the cervical level due to the high risks associated with this procedure at this specific location. Given the above, the requested cervical epidural steroid injection is not medically necessary. In accordance with the above, I have determined that the requested cervical epidural steroid injection (62310, 77003, 99144) is not medically necessary for treatment of the patient's medical condition.

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- 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)
 1. Engel, A., et al. The effectiveness and risks of fluoroscopically guided cervical transforaminal injections of steroids: a systematic review with comprehensive analysis of the published data. *Pain Med*, 2014 Mar;15(3):386-402.
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)