

# **Applied Assessments LLC**

**An Independent Review Organization**

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## **Notice of Independent Review Decision**

### **Review Outcome:**

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

Physical Medicine And Rehab

### **Description of the service or services in dispute:**

Cervical ESI at left C5/6 via catheter

**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)**

The patient is a female with neck pain. On 03/18/13, MRI of the cervical spine revealed central and neural foraminal narrowing at multiple levels secondary to degenerative process. At C5-6, there was mild central narrowing secondary to broad based disc osteophyte complex with bilateral neural foraminal narrowing secondary to disc osteophyte complex more pronounced on left. On the left neural foramen. On 12/17/14, the patient was seen in clinic and her gait was normal and upper extremities strength was full. On 01/05/15, patient returned to clinic and pain was rated 3/10. She reported increasing myofascial symptoms and increased frequency of numbness and tingling affecting her hands especially the left one. On exam, she had full strength in the bilateral upper extremities and cervical epidural steroid injection was recommended.

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

On 01/14/15, utilization review determination letter stated the requested cervical spine epidural steroid injection to the left at C5-6 with catheter was not supported as records dating back to 11/14 contained either a normal neurological examination or no neurological examination so there is no clinical evidence of radiculopathy. Therefore the procedure was not supported. On 02/04/15, a utilization review determination letter noted the requested epidural steroid injection to the cervical spine was not considered medically necessary or medically appropriate as there was lack of physical examination findings consistent with cervical spine radiculopathy. 01/05/15 progress note noted the patient had full strength in bilateral upper extremities. 12/17/14 progress noted the patient the patient had full strength in bilateral upper extremities. Criteria for this procedure would include clinical documentation of radiculopathy by physical examination with corroboration by imaging studies and or electrodiagnostic testing. As radiculopathy has not been documented by physical examination, it is the opinion of this reviewer that the request is not medically necessary and 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)