14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

DATE OF REVIEW: 1/04/2018

IRO CASE # XXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Cervical ESI, Epidurography, Fluoroscopic guidance.

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

D.O. Board Certified in Anesthesiology and Pain Management.

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)

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a XXXX XXXX who sustained a XXXX on XXXX after XXXX XXXX. XXXX complained of cervical pain, left shoulder pain, and left arm pain. On XXXX the patient underwent physical therapy treatment for 3-5 times per week for two weeks with some improvement. An MRI was performed on XXXX which showed a 1mm bulge C3-4, 2mm bulge C4-5 abutting the cervical cord causing mild central canal stenosis at the respective level, and no abnormal signal in cervical cord. Right uncinate spurring causes mild stenosis of C4-5. XXXXX EMG results showed mild nerve irritation, however no sustained denervation of anterior and/or posterior primary rami innervated muscles. Incidental right median sensory entrapment mononeuropathy at the wrist. Patient is taking Naprosyn – no documentation of frequency or duration. On physical exam of the cervical spine ROM was normal, positive tenderness to palpation with associated pain in left shoulder and left arm, pain score 2-3/10. Positive Spurling test, negative axial traction and shoulder abduction test. Patient had slight decrease in sensation in the finger tips on the left.

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

Per ODG references, the requested "Left Cervical ESI, Epidurography, Fluoroscopic guidance" is not medically necessary. The MRI showed no pathology at C7-T1 to support a cervical epidural. The EMG showed mild nerve irritation which does not warrant an epidural. The physician did not establish a radiculopathy with a true dermatomal distribution to support a cervical epidural. Patient had good ROM of cervical spine with no weakness noted in the left upper extremity, DTR's normal. Therefore, a left Cervical ESI with Epidurography under Fluoroscopy is not certifiable.

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 KNOWLEDGE BASE

☐ 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