Notice of Independent Review Decision

Date notice sent to all parties: 7/12/2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of an epidural steroid injection at C6.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation.

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 reviewer agrees with the previous adverse determination regarding the prospective medical necessity of an epidural steroid injection at C6.

PATIENT CLINICAL HISTORY [SUMMARY]:
On XX this XX XX sustained an injury XX that exploded. XX initially was diagnosed with low back pain, radiculopathy, and disc displacement. XX underwent lumbar discectomy at L4-5 on XX. XX had a revision of L4-5 XX. The patient was complaining of shoulder pain and neck pain. A cervical MRI was ordered. On XX the cervical MRI showed mild loss of disc height with disc bulge and no stenosis or neuroforaminal narrowing. No impingement of the C5-6 root is appreciated. The patient does have numbness, pain and tingling. There is no evidence of radiculopathy on clinical exam.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
There are serious risks to these procedures. There is no quality evidence of benefit. This treatment is recommended if there is radicular pain. This is defined as pain in a dermatomal distribution. Radiculopathy must be documented by

physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The pain and radiculopathy must be unresponsive to conservative treatment. ESIs are not recommended higher than the C6-7 level. The ODG, treatment index, 16th edition, web, neck and upper back, ESI Cervical ESI is not recommended per ODG or supported by documentation. The notes do not support the need for a cervical ESI; therefore, the request is not medically necessary.

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 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)**