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IRO Cert#5301

DATE OF REVIEW: APRIL 17, 2018 AMENDED JUNE 26, 2018

IRO CASE #: XXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of the proposed Cervical Epidural Steroid Injection @ C7-T1 using Fluoroscopy X 1 (77003, 62321)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Neurology and Pain Management and is engaged in the full time practice of medicine.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

XX Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX who sustained a work-related injury on XX when a XX XX during XX work as a XX. CT scanning of the head and cervical spine was performed that day. However, only the first page of that report is included in the records – which includes a partial description of the findings in the head, but no description of the findings in the C-spine. The additional pages of the report were missing in the available records for this review. An EMG/NCV report on XX summarizes the reason for this exam as being neck pain with paresthesias radiating into the entire length of the left upper extremity. The conclusion from this study was that there was "no frank evidence of radiculopathy".

The patient was evaluated by XX for a new pain management consultation on XX. That particular note is not included in the records. The follow-up occurred on XX, where XX documented that "the patient continues to have severe pain in XX neck with numbness into XX arms" – with complaints of paresthesias into the left upper extremity. Medications at this time included XX, ibuprofen, and XX. XX examination on that day demonstrated "decreased sensation to light touch in the distribution of C6 bilaterally, worse in the left arm". The plan was to re-submit a request for a cervical epidural steroid injection – which had been denied from a request made at the time of the initial visit. The next office visit with XX took place on XX, by which point XX had undergone surgery to the left shoulder, followed by physical therapy, and was now on XX for pain treatment. Examination now included findings of swelling and discoloration in the left arm, bringing up a concern that "XX may be developing XX XX XX XX". XX was started on XX as well as XX, and continued on XX. XX indicated that they "may consider stellate ganglion block" – depending on progress.

On XX, the patient followed-up with XX and continued to report "neck pain located on the left with radiation into the left shoulder and upper arm with associated numbness". The CT scan findings were summarized in this progress note as showing "a disc herniation on the left at C5-6 with moderate neuroforaminal stenosis". XX also documented that the patient "has tried and failed conservative care to include physical therapy and medication management without relief". XX remained on XX, XX ,XX, and ibuprofen. Examination now was documented as showing some

weakness in the left deltoid, biceps, triceps, and hand grip. Sensory exam still demonstrated reduced light touch in the "left shoulder and lateral aspect of the left forearm". XX increased XX dose of XX and planned to resubmit for a cervical epidural steroid injection "given XX physical exam demonstrating radiculopathy of the C5-6 nerve roots which correlates with XX cervical CT scan".

The requested service was denied on XX, and the appeal then denied on XX. The rationales for these denials were noted as primarily being due to the absence of the imaging reports that would corroborate the clinical impression of left-sided cervical radiculopathy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

Rationale: The basis for the prior denials for the requested service appears to be based on the absence of the actual imaging report that showed disc herniation and nerve root compression that correlates with the patient's symptoms. However, I am inclined to take XX summary of the imaging findings in XX progress note at face value. I have no reason to suspect that XX summary of the findings is inaccurate and/or erroneous. I am not sure why the actual report, in its entirety, has been elusive – for the present review as well. However, continuing to deny this next step in treatment based solely on its absence in the submitted records is a disservice to the patient - since a summary of the findings is provided by XX treating physician.

The claimant has described persistent symptoms of radiculopathy, and has exhibited exam findings that support this – including sensory and motor deficits. XX has failed conservative treatment, including physical therapy. Despite continued treatment with NSAID's, opioids, and muscle relaxers, the patient continues to be troubled with significant radicular symptoms. Therefore, the requested cervical epidural steroid injection under fluoroscopy is deemed reasonable and medically necessary.

References: ODG; Clinical judgment and medical experience.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES