



514 N. Locust
Denton, TX. 76201
Off: (940) 239.9049
Fax: (940) 239.0562

Notice of Independent Review Decision

DATE OF REVIEW: 09/04/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s)

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

Licensed in Pain Management & Anesthesiology

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MRI of the cervical spine, , M.D., 03/25/08
- MRI of the brain without contrast, Dr. , 03/25/08
- Examination Evaluation/Addendum, , M.D., 06/03/08, 06/30/08, 07/01/08, 08/11/08
- Letter from Dr. regarding appeal, 06/30/08
- Prescription for Cervical ESI, , M.D., 07/01/08
- Examination Evaluation, , M.D., 07/17/08
- Peer Review Report, Solutions, 07/17/08, 08/04/08
- Adverse Determination, 07/17/08, 08/05/08
- Notice to URA of Assignment of IRO, 08/18/08
- Patient Information Sheet, (no date)
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was injured on xx/xx/xx. Her injuries included her wrist, shoulder and neck. An MRI of her shoulder was taken that demonstrated a partial thickness rotator cuff tear, however the physician stated that he felt she more likely had a full thickness tear based on her physical examination. It was also noted that the patient's shoulder pain and subsequent pathology was directly related to trauma occurring when she fell, injuring her left upper extremity, neck, and head. No other information was provided regarding the injury. Physical therapy was recommended, but surgical intervention was also recommended if the physical therapy did not help her. Her most recent medications include Ibuprofen, Vicodin, and Lyrica.

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

According to ODG treatment guidelines, epidural steroid injections are medically reasonable, necessary, and indicated when there is evidence of cervical disc herniation and nerve root compromise that correlates with either physical examination or electrodiagnostic evidence of radiculopathy. In this case, neither the cervical MRI nor multiple physical examinations have demonstrated such findings. In fact, all of the medical records that have been reviewed have consistently documented the opinions of several doctors that the patient's left shoulder pain is due to partial, if not full, thickness rotator cuff tear. Cervical epidural steroid injections are not indicated for treatment of rotator cuff tears. Therefore, absent cervical MRI findings of disc herniation or nerve root compression, as well as physical examination findings or electrodiagnostic studies consistent with a diagnosis of radiculopathy, cervical epidural steroid injection is not medically reasonable, necessary, or indicated by ODG treatment guidelines. The request, therefore, is not medically reasonable or 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)