

SENT VIA EMAIL OR FAX ON
Nov/09/2010

Pure Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/09/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Epidural Steroid Injection C5-6

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

Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Office note Dr. 04/23/10

MRI thoracic spine 05/25/10

MRI lumbar spine 05/28/10

Office note Dr. 07/01/10, 09/23/10

LESI certified at L4-5 07/30/10

LESI 10/06/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male injured in a motor vehicle accident on xx/xx/xx. He reported injury to the cervical, thoracic and lumbar spine. Diagnoses of C5-6 right disc protrusion and herniation, L4-5 protrusion with radiculitis and thoracic strain have been given. He was seen on 04/23/10 for his injuries. The examination noted no neurological deficits. Mediations and therapy were the recommendations. The claimant underwent a 05/25/10 MRI of the thoracic spine and a 05/28/10 MRI of the lumbar spine.

On 07/01/10, Dr. noted the claimant had cervical pain with radiation to the arms and tingling of the left hand but there were no documented neurological deficits. A 09/23/10 visit with Dr. noted the claimant had ongoing neck pain with right upper extremity numbness and tingling. A cervical MRI was reviewed and reportedly showed a disc protrusion and herniation at C5-6. On examination, the cervical motion was decreased in all planes with decreased strength and mild paresthesias in both hands. Cervical epidural steroid injection was recommended.

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

Based on the records provided, the epidural steroid injections would not be recommended for certification.

The file documents there are complaints of numbness and paresthesia, first in the left hand and then in the right hand. There is notation of weakness but no focal neurological deficit has been documented. There is no specific pattern to the complaints or findings that would be consistent with a corresponding nerve root level, in particular the C5-6 level. The ODG guidelines recommend that an ESI is indicated in the presence of radiculopathy that is substantiated by documented physical examination, imaging studies and/or electrodiagnostic testing. As noted there is no specific radiculopathy on the examinations or by electrodiagnostic testing. While ODG guidelines support the use of epidural corticosteroid injections: "(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies; (2) To help to determine pain generators when there is evidence of multi-level nerve root compression; (3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g. dermatomal distribution) but imaging studies are inconclusive." The intent of the requested C5-6 epidural steroid injection is not clear in the medical file.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Neck and Upper Back: Epidural steroid injection (ESI)

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

ACOEM-AMERICA 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)