

SENT VIA EMAIL OR FAX ON
Sep/17/2010

True Decisions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/17/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical ESI @C6-7 or C7-T1

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 7/22/10 and 8/3/10

Dr. 12/3/08 thru 9/3/10

MRIs 3/17/95, 2/11/92, 7/8/10

OP Report 5/25/95, 3/30/90

PATIENT CLINICAL HISTORY SUMMARY

This is a woman who reportedly has cervical and lumbar postlaminectomy syndrome. She had a cervical fusion in 1995. It appears she has had ongoing neck pain and pain to the right upper extremity. Dr. noted hypoesthesias in the right C5, C6 and C7 dermatome. An MRI 7/8/10 showed the C5/6 and C6/7 fusion with multiple level degenerative changes. There is some lateral recess stenosis from degenerative changes. Right-sided reflexes are normal.

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

The ESI is for transient relief of a radiculopathy. The ODG requires that there be evidence of a radiculopathy, with dermatomal pain and clinical findings of a radiculopathy. There are no EMG reports. The MRI shows a possible radiculopathy based upon the lateral recess degenerative changes. There are the clinical findings of reduced sensation in multiple dermatomes. Therefore a radiculopathy is present. Dr. is approaching the ESI as a therapeutic treatment. As the ODG states "Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit." Surgery is not being considered. The ODG clearly supports the use of the ESI as an adjunct to a more active program. The IRO reviewer did not see this being considered in the notes provided by Dr.. He wrote the ESI was needed as the "Patient continues to suffer from severe neck pain and RIGHT (his emphasis) arm pain. Secondary to continuing neurological deficit and her recent MRI recommended cervical epidural steroid injection." Again, the ODG does not support this cervical ESI as an isolated treatment. 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-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)