

US Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/07/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

C2/3 Transforaminal Epidural Steroid Injection 64479 77003

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

M.D., Board Certified in Anesthesiology and Pain Management

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

Official Disability Guidelines

Review Determinations, 7/15/10, 8/6/10

Email, 7/14/10

Consultants, 6/21/10, 5/18/10, 1/8/10, 7/28/10, 3/30/10, 3/2/10, 2/19/10

Cervical Myelogram, 11/24/09

Procedure Note, Cervical Facet Steroid Injection, 5/4/10

Report of Medical Evaluation, 5/20/10

PATIENT CLINICAL HISTORY SUMMARY

This patient is a female who was injured while performing her job on xx/xx/xx. According to the 7/28/10 office visit note, she complains of left sided neck pain, tingling, and numbness over the left side of the neck and suboccipital region. It is also noted that the patient has occasional numbness and tingling in the left arm. There are no radicular findings noted in the physical exam performed on 7/28/10. A CT scan and myelogram performed on 11/24/09 was significant for left C2-3 facet joint hypertrophy that mildly narrows the left C2-3 neural foramen. An EMG performed on 1/8/10 did not show any cervical abnormalities. The patient has failed medication management, injections and physical therapy according to the records provided.

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

According to the Official Disability Guidelines for ESI, ESI is considered appropriate if "radiculopathy... (is) documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In this patient's case, the physical exam does not show any objective findings of radiculopathy. A Spurling's test was not documented. In addition, the CT myelogram did not show any significant neuroforaminal stenosis at the C2-3 level (documented as "mild stenosis") and the EMG was normal. Based on this information, the request for a cervical ESI is not medically necessary at this time. This is because the request for C2/3 Transforaminal Epidural Steroid Injection 64479 77003 does not satisfy the ODG and the provider has not stated why there should be a divergence from the ODG.

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. There is no medical necessity for C2/3 Transforaminal Epidural Steroid Injection 64479 77003.

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)