

SENT VIA EMAIL OR FAX ON
Apr/14/2011

Applied Assessments LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/06/2011

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)

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

Board Certified Anesthesiologist/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

OD Guidelines

1. Cover sheet and working documents No Date
2. Fax cover sheet dated 03/30/11, 01/14/11
3. Letter dated 03/30/11, 03/28/11, 03/07/11
4. Confirmation of receipt of a request for a review by an IRO dated 03/25/11 and IRO documents
5. Utilization review determination dated 02/24/11, 03/09/11
6. Preauthorization request dated 02/18/11, 03/03/11
7. Pain management follow up visit dated 02/15/11, 01/06/11
8. EMG/NCV dated 01/31/11
9. Letter of reconsideration dated 02/28/11
10. Neurologic consultation dated 01/24/11
11. Encounter notes dated 12/03/10
12. Consultation/referral request dated 01/12/11
13. Urgent request for medical records dated 03/28/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. The earliest available medical record submitted for review is dated 12/03/10. On the date of injury the patient was going upstairs while carrying several items. She misstepped and fell into the stairs impacting her left hand, right forearm and left knee. The patient continues to work, but complains of poor right hand grip and dexterity, right arm numbness with driving and poor reaching ability above the right shoulder. Pain management extended office visit dated 01/06/11 indicates that the patient has undergone physical therapy and pharmacotherapeutic management. MRI of the cervical spine reportedly showed disc bulges from C4 to C7 which superimposed disc protrusions from C5-6 to C6-7. The patient was previously recommended for cervical epidural steroid injection which was never scheduled. The patient noted improvement of her symptoms over the summer of 2010. In October of 2010 when cold weather returned, she did awaken

suddenly one morning with a VAS pain score of 10 in her right neck with complete numbness and paralysis in her right arm. Surgical history is negative. Medication is OTC Advil. Neurologic consultation dated 01/24/11 indicates that if it is cold, the patient's right face will feel heavy. She gets right elbow pain about 3 times a week. Neck pain continues and worsens with stress. On physical examination she has full range of motion of the neck. Strength is 5/5 throughout the bilateral upper extremities. Reflexes are 2 at the biceps, 2+ at the brachioradialis, 1 at the triceps. Sensory examination is intact. Dr. overall conclusion is that she has a cervical neuralgia versus cervical radiculopathy, and the patient was recommended for EMG/NCV. EMG/NCV dated 01/31/11 indicates a right cervical radiculopathy at C5 to C6 and C6 to C7. Pain management follow up note dated 02/15/11 indicates that there is limited range of motion of the cervical spine. Deep tendon reflexes are 2+ and equal bilaterally. Neurosensory testing did show a deficit on the right at the C5 and C6 dermatomes and motor strength testing was 5/5 bilaterally. The patient was recommended for cervical epidural steroid injection.

Initial request was non-certified on 02/24/11 noting that the level to be injected was not documented, and there are discrepancies in physical examination findings. The denial was upheld on appeal dated 03/09/11 noting that the patient was authorized to undergo a cervical epidural steroid injection on 03/04/10; however, it is unclear if this injection was performed.

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

Based on the clinical information provided, the request for 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) is not recommended as medically necessary, and the two previous denials are upheld. The patient has undergone an MRI of the cervical spine; however, the report of this study was not submitted for review. The patient was seen for neurologic consultation on 01/24/11 and physical examination revealed full range of motion, 5/5 strength throughout, symmetric reflexes and intact sensory examination. The patient was subsequently seen in follow up on 02/15/11, approximately 3 weeks later, and physical examination revealed a sensory deficit on the right at the C5 and C6 dermatomes. There is no explanation provided for this discrepancy in serial physical examinations. There is no comprehensive assessment of treatment completed to date or the patient's response thereto to establish that the patient has been unresponsive to conservative care. The request is nonspecific and does not indicate which level/s are to be injected. Given the current clinical data, the request is not indicated as medically necessary, and the two previous denials are upheld.

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)