

SENT VIA EMAIL OR FAX ON
Dec/02/2011

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Dec/02/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Cervical Epidural Steroid Injection at levels C5/C6, single injection as outpatient.

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Orthopedic spine surgeon, practicing neurosurgeon

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
Cover sheet and working documents
Utilization review determination dated 10/11/11, 10/28/11
Operative report dated 09/06/11
Letter dated 10/23/11
RME dated 05/02/11
Procedure orders
MRI cervical spine dated 08/05/10
Office visit note dated 09/14/10, 09/28/10, 10/04/10, 12/06/10, 02/07/11, 04/07/11, 07/07/11
MRI lumbar spine dated 01/27/11
Neuropsychological evaluation dated 03/28/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was working as a when there was an explosion in the pipe rack above his head; he was thrown 30 feet and

debris fell on him. MRI of the cervical spine dated xx/xx/xx revealed posterior protrusion-subligamentous disc herniation in the central and paracentral region in both sides at C4-5 measuring 3-3.2 mm in AP diameter, indenting the thecal sac, but not touching the spinal cord. At C5-6 there is posterior protrusion-subligamentous disc herniation in the central and right paracentral region, but mainly to the right measuring 3-3.2 mm in AP diameter, indenting the thecal sac, touching the spinal cord. The patient previously injured the neck when he was a pedestrian that was struck by a vehicle. The patient underwent trigger point injections on 09/28/10 and 10/04/10. The patient underwent interlaminar epidural steroid injection T1-T2 on 09/06/11.

Initial request for cervical epidural steroid injection was non-certified on 10/11/11 noting that the only available medical record is an operative note of 09/06/11 indicating the patient underwent an interlaminar epidural steroid injection at T1-2. There is no documentation of symptomatic or objective evidence of cervical radiculopathy. The denial was upheld on appeal dated 10/28/11 noting that there is no MRI evidence provided for review to document nerve root compression. The claimant has no radiculopathy documented on physical examination. There have been no lower levels of care such as physical therapy or anti-inflammatories or muscle relaxants.

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 cervical epidural steroid injection at levels C5-6, single injection as outpatient is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review to establish that the patient has undergone a course of physical therapy as required by the Official Disability Guidelines. There is no current, detailed physical examination submitted for review to establish the presence of active cervical radiculopathy. Given the current clinical data, the requested cervical epidural steroid injection is not indicated as 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)