SENT VIA EMAIL OR FAX ON
Feb/07/2011

Pure Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Feb/07/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient Consultation for cervical spine epidural steroid injection and one cervical spine epidural steroid injection

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:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY
This is a male with a date of injury of xx/xx/xx. The claimant was involved in an explosion, which threw him in the air. The MRI of the cervical spine from 08/05/10 revealed at C4-5, posterior protrusions subligamentous disc herniation in the central and paracentral region in both sides measuring 3-3.2 millimeter in AP diameter, indenting the thecal sac, not touching the spinal cord. At C5-6, there was posterior protrusion subligamentous disc herniation in the central and right paracentral region but mainly to the right measuring 3-3.2 millimeter in AP diameter indenting the thecal sac, touching the spinal cord. Dr. evaluated the claimant on 10/04/10 for neck pain and increased pain with arm usage above the shoulders. Examination

revealed mild loss of motion and spasm. Motor and sensation was intact. Dr. reviewed the MRI. Diagnosis was cervical spondylosis without myelopathy and displacement of the cervical intervertebral disc. Trigger point injections were performed. Dr. recommended a consult for cervical epidural steroid injection, bilaterally if needed, at C3-7. Dr. saw the claimant on 11/17/10. Examination revealed intact neuro. X-rays that day of the cervical spine showed normal alignment, no dislocation and mild arthritic changes compatible with age. Impression was cervical and lumbar sprain. Medication and physical therapy were recommended.

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

The evidence based ODG criteria discuss the indications for epidural steroid injections. They specifically state that radiculopathy must be documented by physical examination and corroborated by imaging studies. For individuals to be considered candidates they should be initially unresponsive to conservative measures.

The most recent office from 10/10 and 11/10 describe limitation of range of motion of the cervical spine and complaints of neck pain which increases with use of arms above the shoulder level. That said, the records do not describe radicular arm pain, dermatomal numbness, weakness or reflex change, nor do they specifically identify on the MRI scan obvious nerve compression that would that would be consistent with the claimant's diffuse neck and upper extremity complaints.

At this point in time the request for cervical epidural steroid injection cannot be considered reasonable and medically necessary. There are virtually no findings that clearly identify a distinct neural compressive lesion that would account for the individuals pain complaints, nor is there objective evidence on examination of the diagnosis of radiculopathy, thus the request cannot be viewed as reasonable and medically necessary.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates, chapter neck and upper back

Criteria for the use of Epidural steroid injections, therapeutic:

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)