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Notice of Independent Review Decision

DATE OF REVIEW: 01/05/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Second cervical ESI with sedation

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

Board Certified in Orthopedic Surgery

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Second cervical ESI with sedation - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X-rays of the cervical spine, right shoulder, and thoracic spine interpreted by M.D. dated 10/17/06

An MRI of the cervical spine interpreted by Dr. dated 11/03/06
An evaluation with M.D. dated 08/10/07
Evaluations with D.O. dated 02/08/08, 10/18/10, 11/18/10, and 12/21/10
A procedure note from Dr. dated 10/20/10
Letters of non-authorization, according to the Official Disability Guidelines (ODG),
from at dated 11/29/10 and 12/13/10
A letter of adverse determination, according to the ODG, from M.D. dated
11/29/10
A letter of appeal from Dr. dated 12/06/10
A letter of adverse determination, according to the ODG, from M.D. dated
12/10/10
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

X-rays of the right shoulder, cervical spine, and thoracic spine interpreted by Dr. on xx/x/xx showed straightening of the cervical spine, spondylosis, and moderate spondylosis of the thoracic spine. An MRI of the cervical spine interpreted by Dr. on 11/03/06 showed 2 mm. generalized bulging of the annulus fibrosis at C5-C6. On 08/10/07, Dr. recommended continued physical therapy and a home exercise program. On 02/08/08, Dr. recommended Cymbalta, Darvocet-N, Amitriptyline, possible trigger points, a possible pain management program, and possible injections. On 10/18/10, Dr. recommended a cervical epidural steroid injection (ESI). A cervical ESI was performed by Dr. on 10/20/10. On 11/18/10, Dr. recommended second and third ESIs, continued Paxil, and continued neck range of motion with exercise therapy. On 11/29/10 and 12/13/10, wrote letters of non-authorization for a second ESI. On 11/29/10, Dr. wrote a letter of non-authorization for the ESI. On 12/06/10, Dr. wrote a letter of appeal for the ESI. On 12/10/10, Dr. also wrote a letter of non-authorization for the ESI. On 12/21/10, Dr. continued the patient on Vicodin, Paxil, and Zanaflex.

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

The patient does not demonstrate objective signs or symptoms of radiculopathy based on the documentation provided. She has symptoms essentially in the trapezius and shoulder, which is not radicular. There is no specific physical examination finding that objectively supports the diagnosis of radiculopathy at this time. Further, she has had significant initial phase relief and it is not clear that a second injection will improve her significantly. It is not stated that the patient meets the criteria for IV sedation, although she is noted to be medicated for anxiety. Dr. records do not demonstrate the inability of the patient to maintain appropriate positioning and does not indicate that this was or will be a technically difficult procedure resulting from anatomic variation, which are criteria in the ODG for sedation during an ESI. Therefore, the requested second cervical ESI with sedation is not reasonable or necessary and the previous adverse determinations should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE AND KNOWLEDGE BASE
- 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)