SENT VIA EMAIL OR FAX ON
Feb/25/2011

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Feb/24/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Cervical ESI

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

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
OD Guidelines
1. Cover sheet and working documents
2. Designated doctor evaluation dated 12/28/10
3. Medical records Dr
4. Initial consultation dated 04/21/10
5. Manual muscle testing and range of motion dated 12/13/10, 11/15/10
6. EMG/NCV dated 07/21/10
7. Radiographic report cervical and lumbar spine undated
8. MRI cervical spine dated 05/24/10
9. MRI lumbar spine dated 05/20/10
10. Letter dated 02/10/11
11. Adverse determination notice dated 01/12/11, 01/28/11
12. Post injection physical therapy evaluation dated 12/13/10
13. Operative report dated 11/04/10

PATIENT CLINICAL HISTORY SUMMARY
The patient is a male whose date of injury is xx/xx/xx. On this date the patient was attempting to pull a steel rod up with a rope when he noted the sudden onset of pain and discomfort to the neck, thoracic spine, low back and bilateral shoulders. The patient was initially seen by Drs. and who provided x-rays and managed the patient conservatively.

Initial consultation by Dr. dated 04/21/10 indicates that the patient complains of neck pain, thoracic spine pain and low back pain with radiation to the bilateral lower extremities. Impression reports cervical spine sprain, thoracic spine sprain, lumbar radiculitis and sprain of bilateral shoulders.

Orthopedic consult dated 06/21/10 indicates that the patient complains of pain in the neck and back area with radiation to the upper and lower extremities. The patient's medical history is significant for a cervical injury in 2005 and underwent previous 3 level fusion. The patient states that he does have some permanent nerve damage in his left upper extremity. The report states that the patient has exhausted physical therapy and medication management and was recommended for cervical epidural steroid injection.

MRI of the cervical spine dated 05/24/10 revealed anterior cervical fusion C5 C6 interbody fusion C7 affected anteriorly does not really appear part of the fusion, disc space is still adequately preserved. At C2-3 there is a 2 mm smooth broad based extradural defect, normal central canal. At C3-4 AP dimension central canal 9 mm moderately narrowed, 3 mm extradural defect, bulging disc versus disc herniation spondylosis; bilateral neural foraminal narrowing, moderately advanced bilaterally. At C4-5 superior portion of the fusion although C4-5 is not fused; AP dimension central canal minimally narrowed to 9 mm; bilateral neural foraminal narrowing moderate; no impingement against the exiting nerve root sleeve on the left, mild to moderate narrowing on the right. C5-6 is fused, AP dimension central canal 1.2 cm normal; there is bilateral neural foraminal narrowing worse on the right than the left. At C6-7 there is 2 mm uncinate hypertrophy on the right, high grade neural foraminal narrowing, possible extrinsic compression against the exiting C6 nerve root sleeve on the right. At C7-T1 there is minimal 2 mm right paracentral extradural defect probably not significant; no significant neural foraminal narrowing, no impingement on the exiting nerve root sleeves; fusion appears stable.

EMG/NCV dated 07/21/10 reports electrodiagnostic evidence of a left L5 and S1 radiculopathy, as well as bilateral C8 and T1 radiculopathy with bilateral median neuropathy at the wrist.

Orthopedic report dated 09/16/10 indicates that the patient underwent cervical epidural steroid injection on 09/03/10, and the patient reports, "this gave him very little relief". The patient was recommended for post injection physical therapy. The patient underwent lumbar epidural steroid injection on 11/04/10.

Orthopedic report dated 11/15/10 indicates that on physical examination Spurling sign is positive, reproducing right shoulder and upper arm pain. Spurling's sign is positive only for axial pain on the left. Distally, his motor strength and sensation is intact. Physical examination on 12/13/10 is unchanged. The patient is recommended for CT myelogram of the cervical spine.

Designated doctor evaluation was performed y Dr. on 12/28/10. Treatment to date is noted to include physical therapy (for 3 weeks which did not help), chiropractic treatment, TENS unit (which did not help), ultrasound (for 3 weeks which helped) and injections (for 2 shots which did not help). The patient did not report taking any medications. On physical examination cervical range of motion appeared to be decreased with full effort. Foraminal compression test was positive bilaterally with pain radiating into the shoulders. Diagnoses and extent of injury are listed as cervical and thoracic strain, cervical bulging disc, lumbar radiculitis and bilateral shoulder sprain.

The initial request for cervical epidural steroid injection was non-certified by Dr. on 01/12/11 noting that the patient underwent previous epidural steroid injection on 09/03/10 which "gave him very little relief". The denial was upheld on appeal by Dr. on 01/28/11 noting that the patient had very little relief from the initial injection.

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 is not recommended as medically necessary, and the two previous denials are upheld. The patient underwent initial cervical epidural steroid injection in September 2010 and reported, “this gave him very little relief”. The Official Disability Guidelines support repeat cervical epidural steroid injection only with evidence of at least 50% pain relief for at least 6-8 weeks. Given the lack of adequate response to the initial injection, the requested cervical epidural steroid injection is not indicated as medically necessary, and the 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

[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)