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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Dec/07/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical ESI C7-T1

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

Anesthesiology/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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Designated doctor evaluation 03/26/12
MRI brain 03/08/10
Procedure notes 05/13/11 and 09/07/12
MRI cervical spine 03/08/10
Operative report 05/05/10
Radiographs lumbar and cervical spine 08/04/10 and 12/01/10
Clinical notes 01/17/11-11/13/12
Electrodiagnostic studies 02/21/11
Radiographs cervical spine 03/03/11
MRI cervical spine 10/25/12
Appeal letter 11/27/12
Prior reviews 10/10/12 and 11/09/12
Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury when she slipped and fell. The patient is status post anterior cervical discectomy and fusion from C3 to C5 on 05/05/10. Post-operative radiograph studies through 2010 showed intact hardware from C3 to C5. The patient was seen by Dr. on 01/11 for complaints of continuing low back and neck and right hip pain. No neurological deficits were noted on exam. The patient was recommended for further diagnostic testing. Electrodiagnostic studies on 02/21/11 were for the lower extremities only. Radiograph studies of the cervical spine from 03/11 reported stable findings. The patient underwent epidural steroid injections for the lumbar spine in 2011 and 09/12. Chronic pain management program consideration was recommended by Dr. in 08/12. The patient was recommended for cervical epidural steroid injections at C7-T1 on 10/05/12. MRI of the cervical spine on 10/25/12 revealed prior fusion from C3 to C5. Disc desiccation and disc space narrowing at C5-6 and C6-7 was noted, however. There were no abnormal cord signal or compression deformities. There was a right paramedian focal disc extrusion at C5-6 contributing to moderate to severe compression of the ventral cord and right C6 nerve root. There was also high grade central canal and right foraminal stenosis at C5-6. At C6-7, there was a 4mm disc protrusion contributing to moderate compression of the left ventral cord, as well as left foraminal canal stenosis. Follow up on 11/13/12 stated that the patient had some benefits with medications including muscle relaxants and opioid opiates. Physical examination revealed paraspinal tenderness to the right side with some loss of range of motion. There were sensory deficits present in the right upper extremity, as well as mild motor weakness in the right upper extremity. Positive Spurling sign was also present. The request for a C7-T1 epidural steroid injection was denied by utilization review on 10/10/12 as there was no diagnostic testing performed to corroborate pathology in the cervical spine supporting epidural steroid injections. The request was again denied by utilization review on 11/09/12 as there was no compromise of the spinal canal or neural foramina as of 03/10 MRI study.

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

The requested epidural steroid injection at C7-T1 is recommended as medically necessary based on the clinical documentation provided for review. The most recent MRI study of the cervical spine revealed new progression of disc protrusions at C5-6 and C6-7 contributing to severe canal stenosis and cord compression, as well as moderate to severe right foraminal stenosis at C5-6 and moderate left foraminal stenosis at C6-7. The physical examination findings are consistent with the imaging findings as there is noted upper extremity weakness primarily to the right side with sensory changes and a positive Spurling sign. Given the lack of improvement with conservative treatment to date including physical therapy medication management and as the most updated imaging provided for review revealed extensive progression of the disc protrusions at C5-6 and C6-7, a C7-T1 transforaminal epidural steroid injection would be supported as medically necessary. Per the appeal letter by Dr. he will perform a transforaminal injection at C7-T1 to reach the C5-6 and C6-7 levels. As the clinical documentation provided for review meets the requested and supports the requested service based on current evidence based guidelines, medical necessity would be established at this time and the prior denials are overturned.

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

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

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES