

SENT VIA EMAIL OR FAX ON
Feb/21/2012

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/21/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical ESI @ C7/T1

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

Anesthesiology

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 02/09/12, 02/06/12

Letter dated 02/10/12

Follow up note dated 01/31/12

Procedure note dated 10/07/11, 03/18/11

Radiographic report dated 10/07/11, 03/18/11

MRI cervical spine dated 12/16/10

Electrodiagnostic results dated 12/21/10

Office visit note dated 11/22/11, 10/25/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. MRI of the cervical spine dated 12/16/10 revealed 3-4 mm left paracentral discal substance protrusion/herniation at C3-4 that minimally indents the spinal cord, but results in no significant central canal stenosis. At C4-5 and C5-6 there is a 2-3 mm left paracentral discal substance protrusion/herniation which may contact only the anterior spinal cord surface. EMG/NCV dated 12/21/10 notes the only significant abnormality was fibrillations in the left C6 paraspinous, right C6 paraspinous muscles, and right L5 paraspinous muscles. These abnormalities suggest a bilateral C6 radiculopathy and an L5 radiculopathy on the right. The patient underwent cervical epidural steroid injection at C7-T1 on 03/18/11 and 10/07/11. Follow up note dated 10/25/11 indicates that the patient reports 70% improvement. Follow up note dated 01/31/12 indicates that

current medication is Ultram. On physical examination there is 4/4 left cervical paraspinal tenderness with 30% decreased range of motion and positive sensory deficits in the left lower extremity. The patient reportedly received 75% relief for 8 weeks with cervical epidural steroid injection.

Initial request for cervical epidural steroid injection at C7-T1 was non-certified on 02/06/12 noting that there was no indication from the available documentation/information of any specific objective cervical radiculopathy occurring at this point based on the physical examination findings and workup done to support the need for a third epidural steroid injection. Also, a series of 3 epidural steroid injections is not supported in the guideline criteria. The denial was upheld on appeal dated 02/09/12 noting that there is no support for a series of three epidural steroid injections in either the diagnostic or the therapeutic phase. Only 2 epidural steroid injections are recommended in either diagnostic or therapeutic phase. Moreover, the medical record review did not state the plan for post injection physical therapy or rehabilitation to improve patient's functionality.

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 C7-T1 is not recommended as medically necessary, and the two previous denials are upheld. The submitted physical examination does not establish the presence of active cervical radiculopathy, noting only left cervical paraspinal tenderness with 30% decreased range of motion. The Official Disability Guidelines report that "radiculopathy must be documented by physical examination". Given the lack of documented radiculopathy on physical examination, the requested 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)