

SENT VIA EMAIL OR FAX ON
Jan/24/2012

Applied Assessments LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/24/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Epidural Steroid Injections

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

Board Certified 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 11/14/11, 11/30/11

MRI lumbar spine dated 10/06/11

MRI cervical spine dated 10/06/11

Encounter summary dated 12/02/11, 11/08/11, 09/23/11

Letter dated 01/11/12, 01/16/12

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. MRI of the cervical spine dated 10/06/11 revealed minimal 1 mm disc bulge at C6-7 without visible neural impingement; otherwise unremarkable MRI scan of the cervical spine. Encounter summary dated 11/08/11 indicates that the patient's problems include lumbosacral spondylosis without myelopathy; cervical disc; degeneration of cervical intervertebral disc; cervical stenosis; neck pain;

brachial neuritis or radiculitis nos; back pain and lumbar radiculopathy. Medications include Tramadol, Robaxin and Lexapro. The patient complains of back pain. On physical examination there is tenderness and pain with motion of the neck. Extension and rotation reproduce neck pain. Spurling's is negative. Motor exam notes normal bulk and tone. Sensation is grossly intact, and deep tendon reflexes are 2+ bilaterally throughout.

Initial request for cervical epidural steroid injections was non-certified on 11/14/11 noting that requested was a series of three cervical epidural steroid injections. On cervical MRI there was no disc herniation, high grade foraminal stenosis or nerve root compression. There was no compression of any neurological structure in support of the diagnosis of radiculopathy. The patient's documented signs and symptoms are not convincing regarding radicular pain. The diagnosis of cervical radiculopathy is unsupported. The denial was upheld on appeal dated 11/30/11 noting that ODG does not support a series of 3 epidural steroid injections due to lack of evidence of its practice. The patient's pain is localized to the neck and non-radiating. There is no physical examination evidence of radiculopathy or evidence of neural impingement on MRI.

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 injections is not recommended as medically necessary, and the two previous denials are upheld. The patient's physical examination fails to establish the presence of active cervical radiculopathy, and the submitted MRI does not support the diagnosis. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The request is nonspecific and does not indicate which level/s is/are to be injected. The request is excessive as the Official Disability Guidelines support a single diagnostic injection with repeat injections based on the patient's response to previous injection. Given the current clinical data, the requested cervical epidural steroid injections are 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)