

SENT VIA EMAIL OR FAX ON
Feb/28/2012

True Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/24/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

ESI to C6/7

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 01/12/12, 01/31/12

Letter dated 02/17/12

Office visit note dated 01/05/12, 01/26/12

Handwritten patient history form undated

Cervical MRI dated 11/08/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. The patient reported pain in the neck bilaterally after repetitive episodes of lifting at work. MRI of the cervical spine dated 11/08/11 revealed at C5-6 there does appear to be a paracentral disc herniation on the right of approximately 4 mm with lateral recess encroachment. At C6-7 there is a diffuse disc herniation again slightly more prominent to the right of 3 mm. Office visit note dated 01/05/12 indicates that the patient complains of bilateral upper posterior neck, bilateral mid-posterior

neck, bilateral lower posterior neck, right suprascapular region and right medial scapula pain. Current medications are listed as Tramadol, Cyclobenzaprine and Ibuprofen. On physical examination there is decreased pinprick sensation right C6 and C7. Motor testing is normal. Deep tendon reflexes are 2+/5 bilateral biceps, left brachioradialis and left triceps, and 0+/5 right brachioradialis and right triceps. Spurling's testing was positive on the right and negative on the left.

The initial request for epidural steroid injection to C6-7 was non-certified on 01/12/12 noting that there are physical examination findings that outline a cervical neurologic deficit finding on the right at C6-7, but there is no corroboration from imaging. The denial was upheld on appeal dated 01/31/12 noting that objective findings do include decreased reflexes and decreased sensation as well as muscle weakness in dermatomal distribution; however, there is nothing in the documentation to support sedation.

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 epidural steroid injection to C6-7 is not recommended as medically necessary, and the two previous denials are upheld.

Although the patient's physical examination notes objective findings of decreased reflexes, decreased sensation, muscle weakness in a dermatomal distribution and positive Spurling's test on the right, the submitted cervical MRI dated 11/08/11 does not support a diagnosis of radiculopathy. The Official Disability Guidelines note that radiculopathy must be documented on physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Additionally, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review to establish that the patient has been initially unresponsive to conservative treatment.

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)