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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/22/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

ESI at C3-C4 cervical spine with IV sedation

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

M.D., Board Certified Anesthesiology; Board Certified 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. The reviewer finds there is not medical necessity for the requested ESI at C3-C4 cervical spine with IV sedation.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Cervical myelogram dated 05/12/08
Cervical CT myelogram dated 05/12/08
Clinical evaluations Dr. dated 11/16/11-03/07/12
Referral form dated 02/07/12
Preauthorization request dated 02/02/12
Office visit notes Dr. dated 04/12/12-05/16/12
MRI cervical spine with and without contrast dated 05/03/12
Office visit note Dr. dated 08/13/12
Test form 08/29/12
Work Comp profile undated
Peer review report dated 09/05/12
Utilization review determination dated 09/05/12
Utilization review determination dated 09/13/12
Peer review report dated 09/13/12
Utilization review determination dated 09/17/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whose date of injury is xx/xx/xx. He was injured while unloading trucks. He has a history of 3 prior cervical fusion surgeries, with the last surgery in 2003.

The claimant reports that in 2008 he experienced recurrence of neck pain with migratory symptoms of numbness, weakness, and tingling in the left shoulder and arm. MRI of the cervical spine on 05/03/12 revealed postoperative changes with extensive anterior cervical fusion hardware at C4, C5, C6 and C7 for 3-level anterior cervical fusion. Significant degenerative disc disease was seen at C3-4 with extensive discogenic bone marrow edema, central spinal stenosis, and marked left foraminal stenosis. Plain radiographs of the cervical spine from 04/12/12 were noted to show a 3-level fusion involving the cervical spine at C4-5, C5-6, and C6-7 with anterior plating and screws at the upper and lower disc space effusion. The fusion looked well healed. He has good cervical lordosis at that particular level. He is noted to have adjacent segment disease at C3-4 with some evidence of retrolisthesis of C3 onto C4 with disc space collapse as well.

A request for left transforaminal epidural steroid injection at C3-4 cervical spine with IV sedation was determined as not medically necessary per peer review report date 08/31/12. Reviewer noted there was no indication that the claimant has undergone any recent active treatment of the cervical spine. The claimant reportedly has undergone previous injections with short-term results. There is no current physical examination from office visit note dated 08/13/12. Official Disability Guidelines for repeat epidural steroid injection requires documentation of at least 50% pain relief for 6-8 weeks. A reconsideration/appeal request for left transforaminal epidural steroid injection at C3-4 cervical spine with IV sedation was determined as not medically necessary per review dated 09/13/12. It was noted that the claimant is surgical and awaiting surgery on his neck so doing an epidural steroid injection would be a palliative measure at best, and not indicated. Second, the neurological exam of 05/12 is normal, while the 08/12 note has no exam so there is no clinical support for an epidural steroid injection. Finally, the MRI showed only stenosis at C3-4, but no HNP or nerve impingement so that result also fails to meet ODG criteria for an epidural steroid injection.

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

The claimant reportedly was injured in xxxx. He has undergone 3 separate cervical fusion procedures with the most recent surgery in 2003. The patient presented with complaints of recurrence of neck pain with migratory symptoms of numbness, weakness, and tingling in the left shoulder and arm. A MRI performed on 05/03/12 revealed postoperative changes with 3-level fusion at C4-C7, with significant degenerative disc disease at C3-4, with extensive discogenic bone marrow edema, central spinal stenosis, and marked left foraminal stenosis. Examination on 05/16/12 revealed no evidence of motor or sensory deficits. Hoffman's sign was negative bilaterally. Lhermitte's sign also was negative. The patient was recommended to undergo artificial disc replacement at C3-4. He was seen in follow-up on 08/13/12, but no physical examination findings were documented at that time. The records indicate that the claimant previously underwent epidural steroid injections with short-term results; however, there was no quantification of the percentage of relief obtained following injections, and no indication of duration of relief. Noting that there is no objective evidence of nerve root impingement on imaging, no evidence of neurologic deficits on 05/16/12, and no detailed examination on follow-up of 08/13/12, the request does not meet ODG criteria for epidural steroid injections. Therefore, The reviewer finds there is not medical necessity for the requested ESI at C3-C4 cervical spine with IV sedation.

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)