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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Aug/12/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

C5-C6 Cervical Epidural Steroid Injection

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

Board Certified Neurosurgeon

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:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 06/03/13, 07/10/13
Office note dated 04/09/13, 06/14/13
Orthopedic consult dated 01/11/13, 04/12/13, 04/04/13, 02/11/13
MRI cervical spine dated 02/11/13
X-ray cervical dated 01/10/13, 05/11/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was going down the steps. The patient missed a step, fell and landed on the concrete on her low back area. She states she lost consciousness for approximately 5 minutes. Treatment to date includes x-rays, MRI, lumbar epidural steroid injections and physical therapy. MRI of the cervical spine dated 02/11/13 revealed at C5-6 posterior 1-2 mm disc protrusion presses on the thecal sac with superimposed left posterolateral 2 mm disc protrusion/herniation that narrows the left neural foramen; no right neural foraminal narrowing is present. Office visit note dated 06/14/13 indicates that medications include Biotin, calcium, aspirin, lovastatin, glipizide, lisinopril, janumet, nabumetone, tizanidine, Celebrex and Norco. Pain is rated as 6/10.

Initial request for C5-6 epidural steroid injection was non-certified on 06/03/13 noting that records noted that claimant has been treated initially for low back pain including lumbar MRI, EMG/NCV, epidural steroid injection and surgery proposed for the low back. Office notes on 04/09/13 do not explain why it is now more than one year later that claimant is being treated for neck pain. There is no physical examination provided. The denial was upheld on appeal dated 07/10/13 noting that a progress note from 06/14/13 notes that he claimant has

subjective reports of radiculopathy with no objective physical examination findings confirming radiculopathy. The guidelines would not support cervical epidural steroid injection without true clinical radiculopathy on examination such as abnormal reflex, upper extremity weakness, decreased sensation in a dermatomal distribution, or myotomal muscular loss or atrophy.

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

The patient sustained injuries in xx/xxxx. There is no comprehensive assessment of recent conservative treatment completed such as physical therapy or an active home exercise program. There is no current, detailed physical examination submitted for review to establish the presence of active cervical radiculopathy. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. As such, it is the opinion of the reviewer that the request for C5-C6 cervical epidural steroid injection is not recommended 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)