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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/2/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: cervical epidural steroid injection #1 @ C5-6 using epidurogram and fluoroscopy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D. O. Board Certified Neurological Surgery

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 02/06/13, 02/27/13
Procedure orders dated 02/01/13
Orthopedic consult dated 01/02/13
Manual muscle strength exam dated 01/02/13
MRI cervical spine dated 10/31/12
Radiographic report dated 10/31/12
Reference material

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xxxxxx. On this date the patient was child when the child grabbed her head, pulled her hair, and dragged her head down. MRI of the cervical spine dated 10/31/12 revealed at C5-6 there is a posterior 2 mm disc protrusion/herniation pressing on the thecal sac at the midline with no neural foraminal narrowing. At C2-3, C3-4 and C4-5 there is no disc bulge, herniation or neural foraminal narrowing. Orthopedic consult dated 01/02/13 indicates that the patient complains of pain to her neck and mid back between her shoulder blades. The patient has had six sessions of physical therapy to date. On physical examination her cervical range of motion is diminished in all directions. Romberg sign was negative. Her upper extremity reflexes were 2+ in the biceps, triceps and brachioradialis. Her station and gait were normal. She had tenderness in the cervical spine with palpable spasms. Spurling sign reproduced pain down to her shoulder blades on both sides. She had diminished sensation in digits 2-4 of both hands. Her motor strength was intact in both upper extremities.

Initial request for cervical epidural steroid injection at C5-6 using epidurogram and

fluoroscopy was non-certified on 02/06/13 noting that an objective diagnostic study in the form of a cervical MRI did not reveal the presence of a compressive lesion upon any of the neural elements in the cervical spine. The denial was upheld on appeal dated 02/27/13 noting that the cervical MRI does not note evidence of compression or nerve root impingement. True evidence of objective physical examination findings documenting radiculopathy were not provided as muscular weakness, muscular atrophy or loss of reflex. Failure of lower levels of care including formal physical therapy performed and associated response as well as use of oral non-steroidal anti-inflammatories has not been clearly documented.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on xx/xx/xx and has completed 6 sessions of physical therapy. The patient's objective functional response to physical therapy is not documented. The Official Disability Guidelines note that radiculopathy must be documented with objective findings on physical examination corroborated by imaging studies and/or electro-diagnostic results. The submitted cervical MRI fails to document significant neurocompressive pathology. As such, it is the opinion of the reviewer that the request for cervical epidural steroid injection #1 @ C5-6 using epidurogram and fluoroscopy 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)