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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/14/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Cervical ESI

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. It is the opinion of this reviewer that medical necessity is not established for the request for cervical ESI and the prior denials are upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Continental Airlines encounter forms dated 02/27/10 and 03/03/10
Clinical notes dated 03/08/10 – 07/14/10
Operative report dated 04/14/10
Clinical notes dated 05/24/10 – 08/26/10
Clinical notes dated 11/02/11 – 09/25/12
Computerized muscle testing and range of motion report dated 01/10/11
Peer review dated 10/05/10
Designated doctor evaluation with letter dated 12/30/10
Peer review dated 07/23/12
Impairment rating report dated 08/22/12
RME summary dated 09/21/12
RME report dated 12/05/12
Physical therapy evaluation & plan of care by, PT dated 11/26/12
MRI cervical spine dated 03/17/10
CT myelogram cervical spine dated 04/07/10
Radiographic addendum dated 04/14/10
CT cervical spine dated 07/12/10
Radiographs of the cervical spine dated 10/26/10
Electrodiagnostic study report dated 12/21/10
Radiographs of the cervical spine, unclear date
Clinical notes dated 10/26/10 – 01/10/13
Pain management report dated 01/15/13
Prior reviews dated 02/04/13 and 02/15/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who sustained an injury on xxxxxx while lifting luggage off a conveyor belt. The patient reported feeling a pop in the neck with subsequent pain radiating through the lumbar spine and into the lower extremities. The patient was status post anterior cervical discectomy and fusion at C5-6 on 04/14/10. Post-operatively, the patient had a physical therapy program and post-operative imaging studies revealed an intact cervical fusion at C5-6. The most recent designated doctor evaluation on 11/26/12 revealed diminished range of motion in the cervical spine. No neurological deficits were identified. The patient was placed at statutory maximum medical improvement as of 03/02/12.

Clinical evaluation on 01/10/13 indicated that the patient continued to have neck increased pain in the cervical spine with associated numbness and tingling with weakness in the right hand. Physical examination revealed weakness in the upper extremities on motor strength testing on the right worse than the left with paresthesia in the right C6 nerve root distribution. There was also decreased sensation in the right fourth and fifth digits and grip strength weakness was apparent on the right versus the left. The patient demonstrated loss of range of motion in the cervical spine. The patient was recommended for epidural steroid injections. A pain management evaluation on 01/15/13 indicated that the patient continued to have neck pain and low back pain with radiating pain in the left lower extremity. Physical examination of the cervical spine revealed loss of range of motion on extension lateral bending and rotation. Reflexes of the upper extremities were symmetric. The patient was continued with medications including Vicodin Lidoderm patches and Elavil. The request for a cervical epidural steroid injection was denied by utilization review on 02/04/13 as the patient received prior cervical injections with limited documentation regarding response to details. Given the request was not recommended as there was little evidence to establish that the patient had significant benefit from the prior injections. The request was again denied by utilization review on 02/15/13 as there was limited regarding results from prior injections.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical documentation provided for review does not fully support the requested epidural steroid injection for the cervical spine. In regards to the prior submitted denials, review of the clinical documentation did not definitively show response to prior cervical epidural steroid injections. It is also noted that the current request is not specific as to what level should undergo a cervical epidural steroid injection and this was not clarified by clinical records recently provided from either. There was also limited objective evidence regarding cervical radiculopathy that would reasonably support epidural steroid injections at this time per current evidence based guideline recommendations. The patient has objective findings on physical examination however. There are no updated imaging studies provided for review demonstrating any neurocompressive findings at the pertinent levels that would support epidural steroid injections. Additionally, prior electrodiagnostic studies for this patient were negative for evidence of radiculopathy in the cervical spine and no further electrodiagnostic studies have been performed to date to further support a diagnosis of cervical radiculopathy that would reasonably benefit from the recommended epidural steroid injections. As the clinical documentation provided for review does not meet guideline recommendations for the requested epidural steroid injection, it is the opinion of this reviewer that medical necessity is not established for the request for cervical ESI and the prior denials are upheld.

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)