

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

Notice of Independent Review Decision

DATE OF REVIEW: November 24, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral C1-C2 intra-articular (IA) injection.

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

M.D., Board Certified in Physical Medicine and Rehabilitation with Sub-specialty Certification in Pain Medicine.

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)

I have determined that the requested bilateral C1-C2 intra-articular (IA) injection is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury on xx/xx/xx. The mechanism of injury was a slip and fall on a wet floor. The documentation of 10/24/14 revealed the patient was having neck pain bilaterally, right worse than left. The neck pain was radiating up the back of his head to the shoulder and causing an inability to sleep. The physical findings revealed the cervical spine had tenderness on palpation. The C1 transverse processes on both sides were tender on palpation of the C2 bilaterally of the trapezius muscle and the extension was abnormal. Rotation bilaterally was abnormal. Pain was elicited with motion. The diagnosis included neck sprain with cervicogenic headache and cervical radiculopathy. It was noted the patient was having more neck

pain and headaches, had limited range of motion and no radicular symptoms and responded to the C1-3 intra-articular injection in July 2014 with a 20% reduction in pain. It was documented the patient had a history of anxiety and severe needle phobia. The patient underwent an MRI of the cervical spine on 1/10/14 which revealed disc protrusions at each level from C3 to C7. They were noted to be associated with some contact with the anterior cord but the cord was not compressed or edematous at those sites. There was no substantial neural foraminal stenosis at any level.

A request has been made for bilateral C1-C2 intra-articular (IA) injection. The Carrier indicates per the denial letter dated 11/5/14 that the patient had a C1-C2 IA injection on 7/14/14 with 20% relief noted on 8/14/14 and the last injection provided a subtherapeutic result so repeating the injection is not supported.

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

Based upon the Official Disability Guidelines (ODG), there are no reports from quality studies regarding the effect of facet joint therapeutic intra-articular injections. According to the guidelines, if the injections are successful, there should be initial pain relief of at least 70% and then pain relief of 50% for a duration of at least 6 weeks. The submitted documentation indicates the patient received 20% relief from the prior injection, which is not optimal. There is a lack of documentation of substantial pain relief; as such, there is inadequate support to repeat the intra-articular injection. Therefore, I have determined the requested bilateral C1-2 intra-articular injection is not medically necessary for treatment of the patient's medical condition. The Carrier's denial should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)