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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: May/06/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right C7-T1 interlaminar epidural steroid injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation and Board Certified 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)

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 the reviewer that the request for right C7-T1 interlaminar epidural steroid injection is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. The patient was lifting when she felt pain. MRI of the cervical spine dated 06/07/13 revealed at C7-T1 the facet joints are normal. No disc herniation was identified. There is no significant central or foraminal stenosis. Note dated 06/28/13 indicates that the patient completed a course of physical therapy without any significant improvement. The patient underwent lumbar facet joint injections at L4-5 and L5-S1 on 08/28/13 with greater than 50% relief of her low back pain. Review dated 10/11/13 indicates that diagnosis is lumbar strain. The patient reached maximum medical improvement as of 09/15/13 with 0% whole person impairment. Peer review dated 10/21/13 indicates that diagnosis is a soft tissue myofascial strain of the paravertebral musculature of the cervical and lumbar region of the spine which would have resolved. Additional or continued treatment would not be reasonable, necessary or supported by the Official Disability Guidelines. The patient subsequently underwent bilateral C6-7 transforaminal epidural steroid injection on 11/20/13 which provided approximately 20% pain relief, per follow up note dated 12/17/13. Physical examination on 03/02/14 indicates cervical range of motion is flexion 40, extension 40, bilateral rotation 20, and bilateral side bending 20 degrees. She has a positive Spurling sign inducing proximal neck pain bilaterally. Muscle strength is 5/5 in the upper extremities. She has decreased sensation along the right thumb, right lateral forearm, and right posterior forearm.

Initial request for right C7-T1 interlaminar epidural steroid injection was non-certified on 02/24/14 noting that the clinical documentation submitted for review does provide evidence that the patient recently received an epidural steroid injection at C6-7 level that only provided 20 percent pain relief. The clinical documentation submitted for review did provide evidence

that the patient has decreased sensation consistent with the C7 through T1 dermatomes; however, the imaging study provided for review does not provide any neurological pathology at the requested level. The denial was upheld on appeal dated 04/07/14 noting that the approach to be utilized during the requested injection needs to be clarified. The provider indicated performing a right sided interlaminar injection which is conflicting as an interlaminar injection does not require laterality. The patient's 20 percent decrease in symptoms with the prior epidural steroid injection did not fulfill the criteria for an adequate response.

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 a course of physical therapy as well as lumbar facet injections and cervical epidural steroid injection with 20% pain relief. The Official Disability Guidelines support epidural steroid injections with documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's cervical MRI fails to document any significant neurocompressive pathology at the requested level. MRI of the cervical spine dated 06/07/13 revealed at C7-T1 the facet joints are normal. No disc herniation was identified. There is no significant central or foraminal stenosis. As such, it is the opinion of the reviewer that the request for right C7-T1 interlaminar 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)