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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/04/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: outpatient cervical epidural steroid injection (ESI) at bilateral C6-7

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery and Fellowship Trained Spine 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 the requested outpatient cervical epidural steroid injection (ESI) at bilateral C6-7 is not indicated as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his cervical region. The operative note dated 09/09/14 indicates the patient undergoing an epidural steroid injection in the thoracic region. The clinical note dated 10/21/13 indicates the patient complaining of cervical region pain. The patient also reports low back pain as well. The patient stated that he had been struck by a vehicle during a snowstorm that had slid on some ice. The patient sustained the neck and mid-back injuries at that time. The patient reported chronic stiffness and achiness at that time. The clinical note dated 10/06/14 indicates the patient utilizing Hydrocodone for ongoing pain relief. The patient continued with cervical, thoracic and lumbar region pain. There is an indication that the patient has a significant medical history involving multiple lumbar surgeries. The MRI of the cervical spine dated 11/07/14 revealed a normal disc height at C6-7. A 2mm disc bulge was identified with mild central stenosis. Moderate bilateral foraminal encroachment was identified as well. The clinical note dated 12/01/14 indicates the patient continuing with cervical and thoracic pain. No other information was provided regarding the patient's clinical changes. The clinical note dated 12/15/14 indicates the patient having previously undergone an epidural steroid injection at the cervical spine with some improvement. The patient has been recommended for a C6-7 epidural steroid injection.

The utilization reviews dated 12/10/14 and 01/07/15 resulted in denials as insufficient information had been submitted regarding the patient's clinical presentation in supporting the medical need for epidural steroid injection to the cervical region.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of cervical, thoracic, and lumbar region pain. There is an indication the patient has undergone a previous epidural steroid injection in the cervical region. Repeat epidural steroid injections are indicated in the cervical region provided the patient meet specific criteria to include an objective functional improvement with a 50-70% reduction in pain for 6-8 weeks. No information was submitted regarding the patient's objective response to the previous epidural steroid injections. Additionally, no information was submitted regarding the specific level of the previous injection. Given these factors, it is the opinion of this reviewer that the requested outpatient cervical epidural steroid injection (ESI) at bilateral C6-7 is not indicated as medically necessary 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)