

# C-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Apr/29/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Cervical ESI @ C6-7

**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 Cervical ESI @ C6-7 is not recommended as medically necessary

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
Utilization review determination dated 03/13/13, 02/28/13  
Office note dated 02/21/13, 10/25/12, 09/13/12, 08/02/12  
Procedure report dated 08/24/12, 07/20/12, 02/03/12, 09/28/11  
Follow up note dated 06/21/12, 02/23/12, 01/12/12  
MRI lumbar spine dated 10/20/10  
MRI cervical spine dated 10/20/10  
MRI thoracic spine dated 10/20/10

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. The patient is noted to be status post C3-C6 fusion. MRI of the cervical spine dated 10/20/10 revealed at C6-7 severe disc space narrowing with a 3 mm annular disc bulge flattening the thecal sac; spondylosis of the uncovertebral joints is noted with sever bilateral foraminal narrowing. The patient underwent lumbar epidural steroid injection at L4-5 on 09/28/11, cervical epidural steroid injection at C4-5 and C5-6 on 02/03/12 (60% relief, per 02/23/12 note), cervical epidural steroid injection at C4-5 and C5-6 on 07/20/12 (60% relief for one week), lumbar epidural steroid injection at L4-5 on 08/24/12. Per office visit note dated 02/21/13, pain level is 7/10. On physical examination cervical range of motion is decreased. Strength and tone are diminished due to head and neck pain. There is tenderness at bilateral paravertebral region from C4 through C6 levels. Sensation is intact throughout.

Initial request for cervical epidural steroid injection C6-7 was non-certified on 02/28/13 noting that the patient has had prior cervical epidural steroid injection but the quantified benefit is not fully discussed. Moreover, the patient is asking for stronger narcotic medications which would suggest that the lumbar epidural steroid injection despite the alleged benefit is not that

helpful as he was still describing pain of 7/10 for the low back and 8/10 for the neck. The patient's physical examination fails to establish the presence of active cervical radiculopathy as required by the Official Disability Guidelines. The denial was upheld on appeal dated 03/13/13 noting that there is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient's physical examination notes that sensation is intact throughout. The Official Disability Guidelines require that radiculopathy must be documented by physical examination.

**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 undergone at least two prior cervical epidural steroid injections. The most recent documented cervical epidural steroid injection provided 60% pain relief for only one week. The Official Disability Guidelines require documentation of at least 50% pain relief for at least 6 weeks. Additionally, the Official Disability Guidelines require documentation of radiculopathy on physical examination. This patient's physical examination notes that sensation is intact throughout. There is no documentation of neurologic deficit in a dermatomal or myotomal distribution. As such, it is the opinion of the reviewer that the request for Cervical ESI @ C6-7 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)