

IRO America Inc.

An Independent Review Organization
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IRO REVIEWER REPORT TEMPLATE -WC

DATE OF REVIEW: 10/21/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical epidural steroid injections at C5/C6 and C6/C7.

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

M.D., Neurologist and Fellowship-trained Pain Specialist, Board Certified in Neurology and 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Notification of Determination dated 09/25/07, 10/05/07
2. Imaging reports including cervical spine x-rays on 11/17/06, MRI scan of cervical spine on 04/28/05, MRI scan of cervical spine dated 03/17/04, cervical spine x-rays on 09/23/03, and intraoperative cervical spine x-ray on 06/18/03
3. Operative report dated 06/18/03 for procedure described as microhemilaminotomy and foraminotomy on the left at C5/C6 and C6/C7
4. EMG/NCV report dated 09/06/07
5. Office notes by Dr. dated 09/14/07, 08/17/07, 08/13/07, 03/13/07, 01/19/07
6. Note from the Physical Rehabilitation Department at Hospital dated 01/24/07
7. Office note from Dr. dated 11/17/06
8. Letter of Medical Necessity dated 07/31/06 for TENS unit
9. Office note from 03/14/06 and 01/17/06
10. ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant sustained a work-related injury that resulted in left-sided radiculopathy that eventually was treated with decompression surgery on 06/18/03 consisting of left-sided microhemilaminotomy and

foraminotomy at the C5/C6 and C6/C7 levels, reportedly with good results and symptomatic relief. Notes seem to indicate that there was some return of left-sided radicular symptoms earlier in 2007 with office notes dated 03/19/07 indicating both increasing symptomatology in his “shoulder area” with presentation apparently similar to his prior radicular symptomatology attributed to the spondylosis and degenerative changes at the C5/C6 and C6/C7 levels. An updated cervical MRI scan at that point was mentioned in the note as well as a “conservative approach” including cervical epidural steroid injection series. Office notes on 08/13/07 indicate continued difficulty with pain in the neck and left upper arm described as “severe.” This note mentions that the updated cervical MRI scan as well as x-rays were denied as well as the series of epidural steroid injections. The claimant had been treated with medications for symptomatic control including anti-inflammatory medications, muscle relaxants, and opioids such as Lortab. The claimant did undergo an updated EMG/NCV study dated 09/06/07 that did show apparently some evidence of a “mild, subacute left C6/C7 radiculopathy.” Notes from 09/14/07 indicated that the claimant’s electrical studies as well as clinical symptoms were consistent and likely related to the C5/C6 and C6/C7 levels once again.

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

It seems very clear to this Reviewer that this claimant has done well symptomatically after his cervical spine surgery, but there was a clear return of symptomatology earlier this year, progressively reaching severe levels and even prompting an emergency room visit prior to his 08/13/07 documented office visit. The symptomatology is described as being quite similar to that experienced by this claimant prior to his surgery with the most recent electrical studies documenting some radicular dysfunction that is felt to be “subacute,” (usually meaning several months of presence), at the suspected levels of C5/C6 and C6/C7. Because of the obvious return of radicular symptomatology with this claimant’s prior history, the Reviewer’s medical assessment is that it would be reasonable to proceed with an updated set of cervical epidural steroid injections targeting the suspected nerve roots. The Reviewer considered the ODG Guidelines in the determination of this case, but as discussed above, the Patient’s circumstances were such that the Reviewer determined it was necessary to diverge from the Guidelines.

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)