



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 08/28/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical ESI

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

Board Certified in Anesthesiology
Fellowship Trained in Pain Management
Added Qualifications 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Cervical ESI - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X-rays of the right shoulder, cervical spine, and thoracic spine interpreted by M.D. dated 10/17/06

X-rays of the right shoulder interpreted by Dr. dated 10/24/06

An MRI of the cervical spine interpreted by Dr. dated 11/03/06

An evaluation with M.D. dated 08/10/07

Evaluations with D.O. dated 02/08/08, 05/12/08, and 06/19/08

Procedure notes from Dr. dated 04/30/08 and 05/28/08

A request note from Dr. dated 07/14/08

An initial prospective review, according to the ODG, from D.O. dated 07/15/08

Letters of non-authorization, according to the ODG, dated 07/16/08 and 08/05/08

An appeal prospective review, according to the ODG, from D.O. dated 08/04/08

A note from Dr. dated 08/11/08

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

X-rays of the right shoulder, cervical spine, and thoracic spine interpreted by Dr. on 10/17/06 revealed spondylosis of the cervical and thoracic spines. X-rays of the right shoulder interpreted by Dr. on 10/24/06 were unremarkable. An MRI of the cervical spine interpreted by Dr. on 11/03/06 revealed a disc bulge at C5-C6. On 08/10/07, Dr. recommended continued therapy. On 02/08/08, Dr. recommended Cymbalta, Darvocet-N, Amitriptyline, and possible injections. Cervical epidural steroid injections (ESIs) were performed by Dr. on 04/30/08 and 05/28/08. On 07/14/08, Dr. requested another cervical ESI. On 07/15/08, Dr. wrote a letter of non-authorization for another cervical ESI. On 08/04/08, Dr. also wrote a letter of non-authorization for another cervical ESI. On 08/11/08, Dr. recommended trigger point injections.

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

According to ODG treatment guidelines, ESIs are medically reasonable, necessary and indicated when there is both evidence of cervical disc herniation and nerve root compromise on MRI, as well as corroboration of evidence of radiculopathy on either physical examination or electrodiagnostic testing. In this case, the MRI demonstrated nothing more than a 2 mm. bulge of the annulus, which is neither pathological nor indicative of disc herniation or nerve root compromise of any kind. The patient apparently also underwent EMG studies, which failed to demonstrate any evidence of radiculopathy. Finally, physical examinations by Dr. have consistently documented lack of evidence of radiculopathy with either normal sensation or non-dermatomal decreased sensation, negative Spurling's tests, and no evidence of neurological deficits

such as reflex or motor deficits. Finally, the patient has already undergone two cervical ESIs, obtaining less clinical benefit from the second one than she did from the first one. ODG treatment guidelines, furthermore, do not recommend more than two ESIs to be done, disallowing the practice of “series of three” injections. There is clearly no medical reason or necessity for a third cervical ESI. This patient has no MRI or electrodiagnostic evidence of cervical disc pathology or nerve root compromise and no physical examination evidence of radiculopathy. Having obtained less clinical benefit from the second cervical ESI than she allegedly obtained from the first (although no numeric pain scores are provided following either of the cervical ESIs to quantify the alleged pain relief obtained) there is clearly no reason to perform a third ESI, especially lacking ODG treatment guideline support. The recommendations for non-authorization from the two physician reviewers, therefore, are upheld and the recommended cervical ESI is not reasonable or necessary.

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)**