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## Notice of Independent Review Decision

**DATE OF REVIEW:** 08/20/08

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Outpatient cervical ESI C4-5, 6-7

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

Licensed in Pain Management & Anesthesiology  
Fellowship Trained in Pain Management  
ABA Board Certified in Anesthesiology  
Certificate of Added Qualifications in Pain Management

### **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.

Outpatient cervical ESI C4-5, 6-7 - Upheld

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

- MRI of the lumbar spine and cervical spine, , M.D., 12/21/07
- Examination evaluation/Addendum, , M.D., 01/18/08
- Adverse determination letters, 01/24/08, 03/06/08, 06/19/08, 06/20/08, 06/25/08
- Progress notes, Dr. , 04/09/08, 06/16/08
- Case manager's notes, 04/15/08, 06/25/08
- Letter from Dr. to Dr. , 06/20/08
- Letter from , M.D. regarding denial, 07/31/08
- Notice of assignment of IRO, 07/31/08
- Case manager's notes (no date)
- The ODG Guidelines were not provided by the carrier or the URA.

## **PATIENT CLINICAL HISTORY (SUMMARY):**

The patient was injured on xx/xx/xx when he was involved in a motor vehicle accident. His chief complaints were neck pain, low back pain and shoulder pain. MRI's of the lumbar and cervical spine were performed and the patient's most recent medications include Prilosec, Actos, Divan, Diclofenac, Cymbalta, Trazodone, and Viagra.

## **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 and necessary when there is evidence on a cervical MRI of disc herniation, with corroborative physical examination for electrodiagnostic studies demonstrating radiculopathy. In this case, the cervical MRI does not demonstrate any disc herniation, and physical examination has repeatedly documented no neurologic findings consistent with a diagnosis of radiculopathy. In fact, other than nonspecific weakness, there is no medical documentation of any physical examination findings whatsoever consistent with, or supporting, the diagnosis of radiculopathy. The fact is that this patient has multiple levels of degenerative disc disease, but no disc herniation, spinal canal or foraminal stenosis, spinal cord compression, or nerve root compromise at any level. Absent such MRI findings, as well as physical examination findings consistent with radiculopathy, ***ODG Treatment Guidelines*** do not provide support for performing cervical ESIs. Moreover, and additionally, the patient's subjective complaints of right more than left upper extremity pain and numbness radiating to both arms to the fingertips is entirely nonanatomical and nondermatomal, providing no support or indication for ***ODG Treatment Guidelines*** for cervical ESIs. Therefore, the previous adverse determinations recommending nonauthorization of cervical ESI are appropriate and; therefore, upheld. Cervical ESI, whether at C4-C5 and C6-C7 or at any other spinal level is not medically reasonable, necessary, or indicated.

**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)