

SENT VIA EMAIL OR FAX ON  
Aug/31/2009

## P-IRO Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/25/2009

**IRO CASE #:**

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

Cervical Epidural Steroid Injection

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

Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management  
Subspecialty Board Certified in Electrodiagnostic Medicine  
Residency Training PMR and ORTHOPAEDIC 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Denial Letters 7/28/09 and 8/8/09

Ms. 6/25/09 and 7/23/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a man injured in xxxx shoe underwent a cervical fusion (C5-7) in 2007. He had chronic neck pain on oral opiates. Ms reportedly had some prior improvement with an ESI, but no further information was provided.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The request is obviously for a therapeutic cervical ESI as he had a prior cervical ESI. I do not know when or to what extent it helped. He reportedly has neck pain, but none was described in any specific radicular pattern as required. The Reviewer could not determine what root is being considered for the injection. The only component provided for the cervical exam is the limited motion. Therefore we do not have the requirements for Criteria 1 for a cervical ESI.

There was no information provided to meet criteria 7 and 8. In the absence of this information, The Reviewer cannot accept the medical necessity for the procedure.

Epidural steroid injection (ESI)

**Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy).**

**(1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.**

**(7) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.**

**(8) Repeat injections should be based on continued objective documented pain and function response.**

**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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)