

**DATE OF REVIEW:** 2/13/2009  
**IRO CASE #:**

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

1. Left C5-6, C6-7 catheter assisted ESI with epidurogram.

**QUALIFICATIONS OF THE REVIEWER:**

This reviewer graduated from University of Missouri-Kansas City and completed training in Physical Med & Rehab at Baylor University Medical Center. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 7/1/2006 and Pain Management since 9/9/2006. This reviewer currently resides in TX.

**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)

1. Left C5-6, C6-7 catheter assisted ESI with epidurogram. Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Fax page dated 1/26/2009 & 1/28/2009
2. Independent review organization dated 1/26/2009
3. Independent review organization dated 1/22/2009
4. Clinical note dated 12/10/2008 to 1/21/2009
5. Pre authorization decision dated 12/10/2008 to 1/21/2009
6. Case assignment by dated 1/27/2009
7. Clinical note dated unknown
8. Clinical note by MD dated 1/27/2009
9. Request for IRO dated 1/23/2009
10. Clinical note dated 1/13/2009 & 1/21/2009
11. Pre authorization request appeal dated 1/13/2008
12. Clinical note dated 1/7/2009 & 1/23/2009
13. Clinical note dated 7/23/2008 to 1/21/2009
14. MRI of the cervical spine by MD dated 7/16/2008
15. Outpatient visit dated 1/8/2009
16. Clinical note by MD dated 1/23/2009
17. The ODG Guidelines were not provided

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

This injured employee is a xx year who suffers from neck pain and left arm pain secondary to a bulging cervical disc as visualized on examination. She is positive for left C6 and C7 hypoesthesia upon examination. The provider has recommended Mobic and cervical epidural steroid injections for her condition.

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

This is xx with neck and left arm pain since a work related injury on xx/xx/xx. The claimant was treated with PT, medications, cervical facet blocks and cervical RFTC, cervical traction, and then more cervical PT. A MRI report dated xx/xx/xx reveals multilevel spondylosis with predominant right side findings and no evidence of left side foraminal stenoses or central stenosis. There was no evidence noted of cervical disk herniation. Per Dr. notes she continues to exhibit neck and left arm pain. Exam reveals loss of sensation in the left C6 and C7 dermatome, normal upper extremity reflexes, and normal strength except at the bicep graded 4/5. Cervical ESI was ordered.

Name: Patient\_Name

The recommendation is for denial of cervical ESI to be upheld. The physical exam findings do not correlate with the findings of the MRI dated xx/xx/xx. Given the absence of obvious findings on the MRI to corroborate the physical exam findings, it is not appropriate to proceed with a cervical ESI. This request does not meet the ODG criteria and thus the previous denial is upheld.

**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)

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