

# Wren Systems

An Independent Review Organization  
3112 Windsor Road #A Suite 376  
Austin, TX 78703  
Phone: (512) 553-0533  
Fax: (207) 470-1064  
Email: manager@wrensystems.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jul/07/2010

**IRO CASE #:**

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

Bilateral Cervical Transforaminal ESI at C5-6 Outpatient 64483 (PNR 99144 77003)

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

M.D., Board Certified, American Board of Anesthesiologists

**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**

Official Disability Guidelines Treatment in Workers' Compensation, Chapter: Neck & Upper Back

Workers' Comp Services, 5/14/10, 6/2/10

Orthopaedic Surgery Group 12/1/08, 5/14/10, 4/6/10, 3/22/10, 2/22/10, 1/25/10

**PATIENT CLINICAL HISTORY SUMMARY**

According to the office visit note from xx/xx/xx this patient complains of "neck pain (and upper extremity pain." Whether the right or left is affected is not mentioned. In addition, there is no mention of the specific location of the patient's pain in the arms. A dermatomal distribution cannot be deciphered from the information presented. The physical exam is significant for a positive Spurling test. It does not specify which arms were involved with this finding. There is also documentation of "good sensation" and equal and symmetrical DTR's in the bilateral upper extremities. The records state the patient received a "bilateral C5-C6 transforaminal with great pain relief for more than 80 to 90 percent for more than three months." "Some of the pain is coming back." There is no documentation stating that the pain that the patient is experiencing is presenting in the same manner as the past pain that was treated with an epidural steroid injection. There is no mention of physical therapy being utilized for this current pain. An MRI performed on 12/1/08 is significant for "a small broad central disk protrusion of C5-C6 with mild spinal canal stenosis." A note dated 5/14/10 states that an "EMG was negative for radiculopathy." It does not mention if this was performed on the upper extremities. The note does imply that it was performed on the upper extremities since Dr. is arguing that the normal results should not preclude the patient from receiving an

epidural steroid injection.

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

Per the ODG, “radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.” As stated above, this has not been accomplished in this case. Also, since there is no good description of the patient’s pain provided in any of the documentation, it is difficult to corroborate the information. It is unclear if this is the same pain as the pain that was treated in the past. The ODG also recommends that conservative measures be tried before proceeding with an ESI. There is no mention of physical therapy or a home exercise program being used to treat this pain. For these reasons, the patient does not satisfy the ODG criteria for ESI. The reviewer finds that medical necessity does not exist for Bilateral Cervical Transforaminal ESI at C5-6 Outpatient 64483 (PNR 99144 77003).

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

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