

C-IRO Inc.

An Independent Review
Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/04/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Epidural Steroid Injection @ C5-6 using fluoroscopy and epidurography

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

M.D., Board Certified Orthopedic Surgeon

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

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who sustained a work related injury to his cervical spine on xx/xx/xx as he was trying to. The claimant had an upright MRI of his cervical spine on 08/18/10, which showed moderate disc desiccation at C5-6. There was a 5.0-millimeter central and right paracentral disc protrusion, which mildly impressed the cord. The neural foramina appeared patent. An EMG/NCV on 09/03/10 showed chronic neurogenic changes and mild active denervation at right mid and left lower cervical paraspinal muscles and the muscles innervated by the right C6 and the left C7 nerve roots. Those findings supported right C6 and left C7 mild cervical radiculopathy with chronic neurogenic changes, reinnervation and mild active denervation. There was no evidence suggestive of peripheral neuropathy, myopathy or nerve entrapment of the bilateral upper extremities. When the claimant saw Dr. on 02/08/11, he complained of neck pain, which he rated as 7/10. The claimant reported he had pain that radiated into his bilateral upper extremities with numbness and tingling. On examination the claimant had a positive Spurling's sign reproducing pain into his right upper extremity. He had paresthesias in his right C6 and left C7 nerve root distributions. His motor strength was weakened in his entire upper extremity. His brachioradialis reflex was diminished on his right side as compared to his

left but he had +2 reflexes at the biceps and triceps bilaterally. X-rays of his cervical spine taken in Dr. office revealed decreased disc height at the lower levels. As the claimant had under gone physical therapy and medication with no improvement, Dr. recommended cervical epidural steroid injections. This was noncertified in 2 peer reviews.

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

At this juncture, the reviewer finds that there is medical necessity for Cervical Epidural Steroid Injection @ C5-6 using fluoroscopy and epidurography. The patient is a who reported an injury that occurred on xx/xx/xx and he has neck pain reportedly radiating to his arm in a radicular pattern. Dr. described radicular irritation and paraesthesias in the distribution of right C6 and left C7 nerve roots. MRI showed a disc protrusion and stenosis at C5-6. EMG/NCS showed denervation of C6 and C7. The patient failed conservative care and time, now greater than six months, including medications, physical therapy, stretching, strengthening, range of motion modalities. Thus the requested cervical ESI, as a diagnostic and potentially therapeutic modality in attempt to gain relief of symptomatology and for evaluation of the pain generator, would be consistent with Official Disability Guidelines. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned.

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)