

SENT VIA EMAIL OR FAX ON  
Feb/17/2011

## **P-IRO Inc.**

An Independent Review Organization  
1301 E. Debbie Ln. Ste. 102 #203  
Mansfield, TX 76063  
Phone: (817) 405-0878  
Fax: (214) 276-1787  
Email: resolutions.manager@p-iro.com

### **NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE OF REVIEW:**  
Feb/17/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
OP C-Transforaminal ESI @ C5/6 RT

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

**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 injured employee is a xx-year-old male. The patient was climbing steps when there appeared to be a hole in a stair, and he fell back with a hyperextension injury to the neck. MRI of the right shoulder revealed moderate thickening with increased signal involving the

supraspinatus tendon indicates tendinopathy, no evidence of a full thickness tear; moderate hypertrophy at the AC joint mildly impinges upon the rotator cuff; moderate joint effusion at the shoulder. MRI of the cervical spine revealed right paracentral broad based disc protrusion at C5 and 6 with incomplete marginal osteophytes compresses and displaces the right anterior spinal cord; moderate narrowing of the central canal. At C3-4 there is a focal 2.5 mm posterocentral disc protrusion indenting the anterior thecal sac and contacting the anterior cord; mild narrowing of the central canal.

Initial visit indicates that the patient has been treated conservatively with physical therapy and medications. The patient underwent right C7-T1 epidural steroid injection on 06/17/10. Follow up note dated 07/07/10 indicates that the patient reports, "the epidural injection did nothing to relieve his pain and his pain has already actually escalated".

Office visit note dated 08/11/10 indicates that the patient underwent surgical evaluation and is not a candidate yet for surgery and was recommended for additional physical therapy. The patient's pain is noted to be mostly axial and not radiculopathic.

EMG/NCV dated 10/01/10 revealed findings consistent with cervical radiculopathy at C7-8 on the right. The denervation/reinnervation changes on needle EMG are chronic and moderate. Follow up note dated 10/06/10 reports that the patient's pain is mostly axial pain over about the C7-T1 area. He has no distal type radicular radiation of his pain. On physical examination reflexes are 2+ and symmetric. Sensation is intact. Examination of the cervical spine shows good range of motion in all planes. Spurling's test is negative. Motor strength is 5/5 throughout the bilateral upper extremities. Dr. informed the patient, "since his pain was mostly axial with no subjective or objective evidence of radiculopathy I feel extremely uncomfortable in doing any further cervical injections". Medications include Lunesta, Cyclobenzaprine, Norco, Lyrica and Levothroid.

Follow up note dated 11/03/10 indicates, "the patient on looking back at the epidural injection feels the epidural produced no real benefit". The patient's examinations "have never really supported a diagnosis of a cervical radiculopathy". Note dated 11/17/10 states that the enigma in this patient's case is that his MRI really does not show much in the way of foraminal encroachment at C5-6. His EMG/NCV studies are C7-8 and subjectively the patient is having C7-C8 symptoms.

The initial request for cervical transforaminal epidural steroid injection at C5-6 on the right was non-certified by Dr. on 11/30/10 noting that there is no objective evidence of cervical radiculopathy on recent physical examination. There is no documentation of MRI showing evidence of cervical nerve root pathology or revealing inconclusive findings that may justify the need for a diagnostic epidural steroid injection. There was no objective evidence of failure with initial conservative treatment. A prior epidural steroid injection was reported for lack of benefit. The non-certification was upheld on appeal by Dr. noting that the patient reports no relief with a previous epidural steroid injection and the active treatment program in conjunction with the injection was not documented.

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

Based on the clinical information provided, the request for outpatient C-transforaminal epidural steroid injection at C5-6 Rt is not recommended as medically necessary, and the two previous denials are upheld. Serial physical examinations fail to establish the presence of active radiculopathy with intact sensation, negative Spurling's and 2+ and symmetric deep tendon reflexes throughout the bilateral upper extremities. The patient underwent previous epidural steroid injection on 06/17/10 and reported no benefit. Current evidence based guidelines support repeat epidural steroid injection only with evidence of adequate response to previous injections. The patient's EMG/NCV findings are consistent with radicular findings at C7-8, and the patient is noted to subjectively have C7-8 symptoms. Given the current clinical data, the requested epidural steroid injection is not indicated as medically necessary and the previous denials are upheld.

**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)