



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision

DATE OF REVIEW: 10/11/2012

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral C4-5 transforaminal cervical ESI with Epidurography,
 left C5-6 transforaminal cervical ESI.

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

D.O. Board Certified in Anesthesiology and Pain Management.

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

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	9/21/2012
Preauthorization Determinations	7/23/2012-8/09/2012
Peer Review Note	7/23/2012
Office Visit Notes	8/08/2012
Recommendation Letter Follow Up Note	7/17/2012 7/10/2012
Radiology Report	7/10/2012



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PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a male with a history of MVA on xx/xx/xx. Patient had surgery in 2006, anterior cervical discectomy and fusion at C3-4, C5-6 with persistent post-operative pain. Subsequently, patient had an MRI and X-ray of the cervical spine on July 10, 2012. MRI showed evidence of a prior fusion C3-6 with anterior metallic instrument plate and congenital versus acquired anterior fusion at C6-7. A central disc protrusion was noted with further facet arthropathy and foraminal narrowing. At C2-3 there was a central and right paracentral disc protrusion without any canal or foraminal stenosis and C7-T1 central disc protrusion without any significant canal or foraminal stenosis. A left uncovertebral joint spur was noted at C5-6 causing moderate left foraminal narrowing and questionable contact on the exiting left C6 nerve root. X-ray done on same date showed anterior cervical discectomy at C3-4 and C5-6 without evidence of hardware failure. At July 12, 2012 physical exam, patient had ongoing cervical and paraspinal muscular pain on the left greater than the right. There was tenderness over cervical and paraspinal area, strength in the deltoid, biceps, and brachial radialis 4+ bilaterally, reflexes 1+ bilaterally. Physical therapy and epidural steroid injection was recommended. No medication list was found or noted, or a report from physical therapy.

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

Per ODG, the requested bilateral C4-C5 transforaminal cervical ESI with Epidurography, Left ESI C5-C6 is not medically necessary. The patient was reported to have previous epidural steroid injection without any objective documentation of improvement on physical exam. The patient is not noted to have positive neural impingement on the cervical MRI or by physical exam. There is no electrodiagnostic study that shows or supports a radiculopathy. Patient's physical exam did not have any findings to support a radicular component.

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