

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Dec/27/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical ESI left C5/6 and C6/7

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

Anesthesiologist
Pain Medicine

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:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 10/09/13, 11/20/13
Visit note dated 10/07/13, 10/28/13
CT cervical spine dated 02/04/09
Operative note dated 02/22/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. CT of the cervical spine dated 02/04/09 revealed at C5-6 the neural foramina appear widely patent. There is circumferential vertebral body spurring; there does not appear to be any significant canal stenosis at this level. At C6-7 there is posterior vertebral body spurring slightly narrowing the central canal anteriorly on the left; the bony neural foramina appear adequate. The patient underwent cervical epidural steroid injection at C6-7 on 02/22/13. Visit note dated 10/07/13 indicates that medications include pravastatin, metaxalone, hydrocodone-acetaminophen, metformin, glimepiride, and benazepril. On physical examination strength and range of motion of the upper extremities is normal. Sensation is noted to be intact.

Initial request for cervical epidural steroid injection left C5-6 and C6-7 was non-certified on 10/09/13 noting that the patient has subjective complaints of neck pain radiating to the left shoulder; however, physical examination revealed no evidence of cervical radiculopathy. There is no evidence of a focal disc herniation with nerve root compression at any level of the cervical spine on imaging. There is no assessment of the response to the previous cervical epidural steroid injection performed on 02/22/13. Criteria for cervical epidural steroid injection

as specified by current evidence based guidelines require that radiculopathy be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There also must be documentation of failure of conservative care including physical therapy, NSAIDS and muscle relaxants. Also, repeat injections should be based on continued objective documented pain and function response with at least 50-70% relief lasting at least 6-8 weeks. The denial was upheld on appeal dated 11/20/13 noting that the patient's current physical examination findings fail to demonstrate a specific radicular process, isolated to the two requested levels. Furthermore, imaging for review is from 2009 and does not demonstrate compressive pathology.

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

The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's physical examination fails to establish the presence of active cervical radiculopathy, and the submitted cervical CT scan does not document any significant neurocompressive pathology. The patient underwent prior cervical epidural steroid injection in February 2013; however, the patient's objective, functional response to this injection is not documented. The Official Disability Guidelines require documentation of at least 50% pain relief for at least 6 weeks prior to the performance of repeat epidural steroid injection. As such, it is the opinion of the reviewer that the request for cervical epidural steroid injection left C5-6 and C6-7 is not recommended as medically necessary.

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)