

# Applied Resolutions LLC

An Independent Review Organization  
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## Notice of Independent Review Decision

**DATE OF REVIEW:** 04/12/2008

**IRO CASE #:**

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

Cervical ESI with fluoroscopy

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

Board Certified Neurosurgeon with additional training in Pediatric Neurosurgery

### **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)

Upon independent review the reviewer finds that the requested Cervical ESI with fluoroscopy is not medically necessary.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters 3/6/08, 3/14/08, 02/9/2008  
ODG Guidelines and Treatment Guidelines  
MD Letters to DO 3/17/08, 2/28/08, 2/11/08, 12/17/07, 9/17/07, 7/16/07, 4/19/07,  
1/18/07, 1/8/07, 4/2/07, 12/21/06, 10/26/06, 10/12/06  
Letter 12/6/07  
Plain films of the cervical and thoracic spine reports 3/10/08, 7/16/07, 04/19/2007  
MRI of the cervical spine report 5/17/07  
Myelogram and post-myelogram CT scan of the cervical spine report 1/2/07

Myelogram and post-myelogram CT scan of the lumbar spine report 9/26/06  
Discharge Summaries 4/05/07, 11/29/06  
Operative Reports 1/2/07, 11/28/06, 9/26/06, 4/4/07  
Patient History  
UR Referral  
History and Physical Examination 4/4/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient has a date of injury xx/xx/xxxx when a basket he was working in fell over and flipped on top of him. He is status post C4-C5 and C5-C6 ACDF. He complains of posterior neck pain. An MRI of the cervical spine 05/17/2007 shows postsurgical changes.

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

The procedure is not medically necessary. The patient has no evidence of a radiculopathy. According to the ODG, cervical ESI's are indicated only with objective evidence of a radiculopathy. This patient has neck, non-radicular pain. Therefore, the ESI is not medically necessary.

**References/Guidelines:**

ODG "Neck and Upper Back" chapter

**Criteria for the use of Epidural steroid injections:**

1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.

**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 (PROVIDE A DESCRIPTION)**