SENT VIA EMAIL OR FAX ON
Apr/27/2009

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Apr/27/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Cervical Epidural Steroid Injection @C5-6

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)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 4/2/09 and 3/13/09
MRI's 5/22/08, 8/10/06, 4/19/05
Electromyography Report 3/30/04
Clinic notes Dr. 07/30/2008, 10/14/2008, 01/12/2009, 03/16/2009

PATIENT CLINICAL HISTORY SUMMARY
This is a male with a date of injury xx-xx-xx. He has had a prior C5-C6 ACDF. He has had ESI's 06/2008, 10/2008, and 01/12/2009. A prior injection gave him 75% pain relief for a couple of months, but a subsequent one was done 01/12/2009. He reports return of radicular pain. He has weakness in the right biceps and triceps on examination. An MRI of the cervical spine 05/22/2008 reveals right foraminal stenosis at C5-C6. There is also moderate right foraminal stenosis at C4-C5. The provider is requesting a C5-C6 cervical ESI.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
The procedure is medically necessary. The claimant's condition meets the ODG criteria for

therapeutic ESI's. He has objective evidence of radiculopathy on examination that correlates with his neuroimaging. He has responded positively to ESI's in the past (75% pain relief for two months). He has a recurrence of his radicular symptoms. Therefore, the C5-C6 ESI is reasonable and medically necessary.

References/Guidelines

ODG "Neck and Upper Back" chapter

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)