

SENT VIA EMAIL OR FAX ON  
Jan/27/2010

## Applied Assessments LLC

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jan/27/2010

**IRO CASE #:**

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

ESI Under Fluoroscopic Control with Epidurogram #2 of the Right C7-T1 Region

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Denial Letters 12/7/09 and 11/9/09

DNI 11/20/09, 1/7/10

MRI of the cervical spine report 8/31/09

Neurological Surgery 9/30/09 and 12/21/09

ESI 10/29/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a female with a date of injury xx/xx/xx, when she tripped and fell and struck her left shoulder and left side of her neck. She complains of neck and left arm pain. Her neurological examination is normal. An MRI of the cervical spine 08/31/2009 reveals a broad-based disc-osteophyte complex at C5-C6. There is severe bilateral axillary recess narrowing and advanced neuroforaminal stenosis. She underwent a C7-T1 ESI on 10/29/2009 on the right, which gave her at least 80% reduction in pain. She has failed PT,

activity modification, and pain medication. The request is for an ESI under fluoroscopic control with epidurogram #2 of the right C7-T1 region.

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

The ESI is not medically necessary at this time. The ODG requires that “radiculopathy must be documented” and “objective findings on examination need to be present”. No examination suggests any evidence of radiculopathy. Therefore, her condition does not meet the criteria for ESI, and the procedure is, therefore, not medically necessary.

*Occupational and Disability Guidelines, “Low 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

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)