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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/21/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Cervical Translaminar ESI C7/T1 (with catheter to address C5-C6 bias to the right).

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

M.D., board certified in Orthopedic Surgery

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 Guidelines and Treatment Guidelines

Adverse Determination Letters, 11/30/09, 12/23/09

Orthopaedics 9/28/09

Hospital 8/29/09, 8/3/08, 5/29/09, 6/29/08

CPR 11/24/09, 1/6/10, 11/17/09, 11/23/09

9/13/08

Orthopaedics 11/16/09

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who is stated to have some disuse atrophy of the right deltoid. There is noted to be decreased strength of the biceps and decreased grip strength on the right-hand, mild decreased sensation over the right C6 dermatome to light touch. There is an MRI scan that shows some neural foraminal stenosis on the right at C5/C6. Request is for a cervical selective nerve root sleeve block/epidural steroid injection at C5/C6.

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

The previous reviewer denied this under the assumption that there was no radiculopathy. In this case, the physicians involved have documented the radiculopathy that would be compatible with the level noted on the MRI scan. It is for this reason that this request does, in fact, conform to the Official Disability Guidelines and Treatment Guidelines. Given the presence of radiculopathy with compatible neurological findings and imaging findings, the reviewer finds the previous adverse determination is overturned. The reviewer finds that

medical necessity exists for Cervical Translaminar ESI C7/T1 (with catheter to address C5-C6 bias to the right).

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)