

# I-Resolutions Inc.

An Independent Review Organization  
8836 Colberg Dr.  
Austin, TX 78749  
Phone: (512) 782-4415  
Fax: (512) 233-5110  
Email: manager@i-resolutions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

December 29, 2009

**IRO CASE #:**

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

C5-6 Cervical Epidural Steroid Injection #1 using fluoroscopy and epidurogram

**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**

Adverse Determination Letters, 11/10/09, 12/1/09

ODG Guidelines and Treatment Guidelines

M.D. 10/29/09

Therapy & Diagnostics 10/29/09

Imaging 10/9/09

DO 12/1/09

M.D. 11/10/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker who was injured on xx/xx/xx. The patient has a documented 3-mm to 4-mm herniation at C5/C6. The patient has had conservative care. The patient's physical examination based upon dynamic testing revealed grip strength 33 pound average on the left and 26 pound average on the right with a 21% deficit on the right, which is the 50th percentile below the average for the patient's age and a significant difference side-to-side. The patient also had a positive Spurling's test with radiation into the arm. Current request is for cervical epidural steroid injection.

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

For this patient to meet Official Disability Guidelines and Treatment Guidelines criteria for epidural steroid injection, there must be evidence of radiculopathy. In this case there was a positive Spurling's test. There is weakness in grip strength, which would be compatible with a C5/C6 herniation. It is for this reason, given that the patient does indeed meet the criteria of Official Disability Guidelines and Treatment Guidelines, the previous adverse

determination has been overturned. The reviewer finds that medical necessity exists for C5-6 Cervical Epidural Steroid Injection #1 using fluoroscopy and epidurogram.

**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)