

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: Jun/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Cervical ESI

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

Genex, 5/17/10, 5/21/10

M.D., Ph.D. 2/22/10, 3/26/10, 4/16/10

Medical Care, 2/22/10

MRI, 1/13/10

Health 11/16/09, 11/13/09, 11/24/09

Letter from Injured Employee, undated

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who was driving when she was hit by a vehicle. She complains of axial neck pain with some pain to the trapezius and shoulders. She has a normal upper extremity neurological diagnosis. Her diagnosis is discogenic cervical pain. Current request is for an epidural steroid injection. Previous request for ESI has been denied due to the absence of radiculopathy.

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

The Official Disability Guidelines and Treatment Guidelines indicate that cervical epidural steroid injections are recommended with documentation of radiculopathy upon examination as well as with documentation of failure to respond to conservative care. In this particular instance, the requesting physician has clearly indicated that motor, sensation, and reflexes are all intact. There are no motor or sensory or reflex deficits consistent with a clear-cut radiculopathy. The treating physician has mentioned an article indicating ESI benefit in the treatment of non-radicular cervical pain. The Official Disability Guidelines and Treatment Guidelines are statutorily mandated in the State of Texas. Without documentation of radiculopathy, the previous adverse determination cannot be overturned in the absence of supporting criteria. The reviewer finds that medical necessity does not exist for Cervical ESI.

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)