

SENT VIA EMAIL OR FAX ON  
Apr/21/2010

## IRO Express Inc.

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Apr/15/2010

**IRO CASE #:**

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

Cervical Transforaminal Epidural Steroid Injection Right C5-6 with Flurorscopy

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

Subspecialty Board Certified in Electrodiagnostic Medicine

Residency Training PMR and ORTHOPAEDIC 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**

OD Guidelines

Denial Letters 3/9/10 and 3/19/10

Spine Care 7/16/09 thru 3/11/10

MRI 1/27/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a man injured on xx/xx/xx. He has neck pain and reportedly radicular pain identified as a chronic radiculitis. His MRI from 2009 showed "Minimal disc space narrowing and 1mm disc bulge at C5/6. No significant spinal canoa or foraminal encroachment." There was no comment of nerve root compromise. Dr.'s examination found reduced cervical motion. There was no weakness, atrophy or abnormal reflexes or sensation described.

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

The ODG permits an ESI where there is radicular pain in a dermatomal distribution. That was not described. There must also be corroborative findings on physical examination, radiological finding and electrodiagnostic testing. The neurological exam was normal. There was no EMG (although that is optional) and there was no description of root compression on the MRI. Therefore, he did not meet the requirements for medical necessity of a therapeutic cervical ESI. There was no ambiguity to necessitate a diagnostic ESI. Therefore the procedure is not justified.

**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)