

SENT VIA EMAIL OR FAX ON
Feb/01/2011

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/31/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left C7/T1 Epidural Steroid Injection with Anesthesia

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

Board certified in Physical Medicine and Rehabilitation with expertise in pain management, wound management and geriatrics.

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

PATIENT CLINICAL HISTORY SUMMARY

This man developed neck pain with radiation to the left upper extremity. He reported that the pain began after an injury at work on xx/xx/xx. He has had physical therapy for the shoulder. The progress notes do not detail the response from therapy. He did have injections to the left shoulder. A 10/25/2010 note indicates the patient complains of left hand weakness. On

8/24/2010 a cervical spine x-ray shows C56 HNP and compression of the cord with left sided foraminal narrowing. A CT of the cervical spine shows a 3mm protrusion/herniation at C56

with impingement of the left C7 nerve in the canal. An EMG shows C67 radiculopathy and left median neuropathy and left ulnar neuropathy. The patient has been working at a full time. The notes indicate he is light duty status with a 50-pound lifting restriction. The notes indicate he can stand less than 30 min, sit less than 30 min and work less than 30 min and pain is 7-9/10. There is no evidence that he has had physical therapy for the neck.

There is now a request for a cervical ESI. The request included a request for an anesthesiologist to administer anesthesia for the procedure. There is also a note that he was referred to a neurosurgeon and there is a request for a myelogram. A left shoulder MRI shows supraspinatus tendinopathy, subdeltoid bursitis and AC joint hypertrophy but no rotator cuff tear. He had a left CVA in Dec of 2008 and he has diabetes and hypertension.

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

This claimant has neck pain. He has had therapy and treatment directed toward the left shoulder. The injections and therapy for the shoulder have not been beneficial. He has not had therapy directed toward the cervical spine. There are radicular symptoms, however ESI should be reserved for cases that are refractory to conservative treatment. He was referred for myelogram and to a neurosurgeon. There are no notes available to review the neurosurgical opinion. The request for an ESI with an anesthesiologist present is questionable per a previous anesthesia reviewer.

This request does not meet the OD guidelines, as there has not been documented failure of conservative treatment to the neck.

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)