

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 2, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Lumbar ESI, 62311

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
ee)
- XX Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

| Primary Diagnosis | Service being Denied | Billing Modifier | Type of Review | Units | Date(s) of Service | Amount Billed | Date of Injury | DWC Claim# | IRO Decision |
|-------------------|----------------------|------------------|----------------|-------|--------------------|---------------|----------------|------------|--------------|
| 722.10 | 62311 | | Prosp | 1 | | | | | Overturned |
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PATIENT CLINICAL HISTORY [SUMMARY]:

This individual was seen by Dr. for an injury dated xx/xx/xx. She was being evaluated for a work-related injury and was found to have evidence of back pain and pain radiating to the leg, also complicated by a pulmonary embolism following a hysterectomy requiring anticoagulation treatment and Greenfield filter placement. She shows distribution of nerve pain in L5 and distribution of 4/5 strength. Reflexes were maintained. There is a herniated disc at L4-L5 although the MRI shows the disc to be more left sided than right sided. Dr. 's notes indicate that he would like to try the patient on lumbar epidural steroid injection and if that is unrewarding, he would consider a lumbar laminectomy with microdiscectomy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE: This individual has lumbar radiculopathy with disc disruption. MRIs are imperfect and not always sensitive to abnormalities, but it is abnormal. There is in fact a disc herniation and there is in fact documented strength and reflex changes in the unilateral limb. Therefore, an epidural steroid injection is an appropriate diagnostic and therapeutic measure and meets the proper criteria for International Spine Injection Society for ESI, as well as ODG Guidelines. I therefore recommend this be approved.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- XX OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (ISIS Guidelines for epidural steroid injections.)