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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 1, 2010
IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Medical necessity of proposed Thoracic ESI

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 orthopedic surgery 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:

XX Upheld (Agree)
☐ 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
unk	Thoracic ESI		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW
TDI-HWCN-Request for an IRO-18 pages

Respondent records- a total of 47 pages of records received from FOL to include but not limited to: FOL letter 3.17.10; ODG guidelines Neck and Upper back; xxxxxx letter 2.12.10, 3.3.10; Dr. note 2.22.10; MRI Dorsal spine 1.21.10; xxxxxx 12.7.09-1.8.10; script 2.3.10

Requestor records- a total of 26 pages of records received to include but not limited to:
MRI Dorsal spine 1.21.10; xxxxxx 7.13.09-2.12.10

PATIENT CLINICAL HISTORY [SUMMARY]:
The medical records presented for review begin with a July 2009 evaluation from Dr. who noted a cervicalgia, cervical radiculopathy and chronic intractable pain syndrome. Epidural steroid injections were sought.

The claimant was also seen by Dr., who made the same diagnosis and identified that an electrodiagnostic assessment had been completed. (The results were not presented). The assessment was a cervical foraminal stenosis with cervical sprain, left rotator cuff tear and left wrist sprain. The treatment plan was multiple medications and additional consultation.

Subsequent evaluation noted increasing complaints of pain and Dr. identified that the previous cervical injections had helped ameliorate the pain complaints. Additional injections were sought in December 2009.

Dr. evaluated Mr. and felt that there was a thoracic component to this problem. A thoracic MRI was obtained. This study noted a disc lesion at the T8/9 level. Dr. referred the claimant back to Dr.. It would appear that a thoracic epidural steroid injection was sought. These injections were not certified by the utilization review provider.

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:

As noted in the Division mandated Official Disability Guidelines for a thoracic epidural steroid injections, the standards are listed as

"Criteria for the use of Epidural steroid injections, therapeutic:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

(1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

(3) Injections should be performed using fluoroscopy (live x-ray) for guidance

(4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.

(5) No more than two nerve root levels should be injected using transforaminal blocks.

(6) No more than one interlaminar level should be injected at one session.

(7) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year."

These standards are not met in the progress notes presented for review. Thus, there is no basis fort overturn the determination already made.

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

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- XX 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)