

SENT VIA EMAIL OR FAX ON
Dec/06/2010

Applied Assessments LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Dec/06/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

One (1) outpatient cervical epidural steroid injection (ESI) and six (6) sessions of therapy consisting of therapeutic exercises (24 units), manual therapy (6 units), and electrical stimulation (6 units), totaling six units per session.

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. Medical Director of Rehabilitation.

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 11/1/10 and 11/16/10
Pain Institute 7/17/10 thru 11/8/10
IRO Decision 2/15/10
Dr. 7/18/08
Radiology Reports 10/12/06, 11/11/06, 11/19/06
Electrodiagnostic Report 12/8/06
EMG 8/27/07
Disability Evaluation Center 2/2/09 and 3/4/10
Dr. 4/14/10 thru 9/1/10
DDE 8/14/07 and 1/31/08

PATIENT CLINICAL HISTORY SUMMARY

This claimant has a date of birth of xx/xx/xx. She is 5'7" and 220 pounds. She has had 5 left knee surgeries and 2 right knee surgeries and 1 left foot surgery. She tripped and fell in and reported a knee injury. She had therapy. She had a surgery 8/30/2006 and returned to work. She fell down stairs 9/20/2006 and reported neck, arm, back and leg pain. Her diagnoses are neck sprain, lumbar sprain, chondromalacia patella and brachial neuritis. An MRI shows C4-7 disc bulges consistent with DDD. There is no cord compression. EMG has shown C7 radiculopathy in 2007. There has not been a recent EMG. Clinical examination indicates upper extremity pain but there is no examination reporting pain in a C7 dermatomal pattern. She has had a cervical ESI 4/1/2010 that provided 60 to 70% pain relief. There is now another request for ESI. The patient does continue to work. There is also a request for therapy. A DD examination by Dr. indicates the patient ambulates with normal gait and in no distress. Dr. saw the patient and gave a 20% IR whole body with 5% to the cervical, 10% to the lumbar and 3% to the left lower extremity and 3% to the right lower extremity. She is taking tramadol, skelaxin and ibuprofen for the pain. Her job is a benefits review officer and is sedentary.

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

Epidural steroid injections are recommended as an option for treatment of radicular pain. Radicular pain is defined as pain in a dermatomal distribution and corroborative findings of radiculopathy. There is no recent examination showing the radiculopathy in a dermatomal pattern. There is no recent EMG. MRI does not show nerve compression. There is not documentation of continued pain and dysfunction. The patient is working. There is no documentation that she is continuing a home exercise program, which can be as beneficial for pain as more invasive treatment. She is using medications for control of pain

Therapy is not indicated for an injury that occurred in xxxx. The patient can perform an independent exercise program, as recommended by the ODG. She is working. The request is not medically necessary.

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 KNOWLEDGBASE

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)