



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

DATE OF REVIEW: 12/22/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral transforaminal epidural steroid injection at C3/C4 under fluoroscopy

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in private practice of Pain Management full time since 1993

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

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

The ODG criteria for epidural steroid injection has not been met.

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
723.4	77003		Prosp						Upheld
723.1	64479		Prosp						Upheld
723.1	99144		Prosp						Upheld

INFORMATION PROVIDED FOR REVIEW:

- Case assignment.
- Letters of denial 10/02 & 11/02/09, including criteria used in the denial.
- MMI report 08/27/09.
- Orthopedic surgery evaluation and follow up 04/16/09 – 09/27/09.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This individual sustained a work-related motor vehicle accident on xx/xx/xx. There is primarily low back pain and also neck pain. Physical therapy has been provided. The majority of the treatment was directed towards the low back. The patient is obese and has non-insulin dependent diabetes and hypertension. Cervical MRI scan shows degenerative changes at C6/C7. There is no documentation of neurological deficit.

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

<p>P. O. Box 215 Round Rock, TX 78680 (1908 Spring Hollow Path, 78681) Phone: 512.218-1114 Fax: 512.287-4024</p>	
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The ODG Guidelines require documentation of radiculopathy. The cervical MRI scan does not show nerve impingement. There is no deficit on physical examination and no report of abnormal EMG findings in the upper extremities. Thus, the criteria have not been met.

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

- ACOEM-American 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)

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