

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 12/28/2009
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Injection, single (not via indwelling catheter), not including neurolytic substances with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s)

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from University of Missouri-Kansas City and completed training in Physical Med & Rehab at Baylor University Medical Center. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 7/1/2006 and Pain Management since 9/9/2006. This reviewer currently resides in TX.

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)

Injection, single (not via indwelling catheter), not including neurolytic substances with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Fax page dated 12/08/2009
2. IRO request form by author unknown dated 12/08/2009
3. Notice to air analyses by dated 12/08/2009
4. Notice of assignment by dated 12/08/2009
5. Letter by dated 12/07/2009
6. Request for a review dated 12/01/2009
7. Letter by dated 11/20/2009
8. Letter by dated 11/04/2009
9. Letter by dated 11/04/2009
10. Fax page dated 10/30/2009
11. Reconsideration by dated 10/28/2009
12. Letter by dated 10/14/2009
13. Form by author unknown dated 10/07/2009
14. History note by author unknown dated 10/07/2009
15. MR cervical spine by MD dated 07/30/2009
16. Official Disability Guidelines (ODG)

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This injured employee is a female who was injured on x/xx/xx. A note from Dr. notes the injured employee was seen on 10/7/09, having had cervical tingling and pain for the last 5 months. She has numbness of the right shoulder and pain when bringing her head down. The injured employee has had 5 sessions of physical therapy (PT) without relief. A cervical MRI from 7/30/09 reveals a C4/5 and C5/6 broach-based disc osteophyte complex effacing the subarachnoid space causing minimal to mild central spinal stenosis. The neuroforamen are well-preserved at each level. There are mild degenerative changes at C3/4 and mild left foraminal narrowing at C6/7.

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

According to ODG criteria for the use of epidural steroid injections, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The provided documentation is insufficient to support a clinical diagnosis of radiculopathy. There are no physical examination findings, significant MRI findings or electrodiagnostic findings to suggest a diagnosis of radiculopathy. Based on these factors, the request for cervical epidural steroid injection is not medically necessary.

The recommendation is to uphold the prior denials regarding the request for cervical epidural steroid injection.

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
- 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)