

SENT VIA EMAIL OR FAX ON
Jan/22/2010

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/20/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Therapeutic Tranforaminal Cervical Epidural Steroid Injection @ C7-T1 and Local Anesthetic Joint Injection to Left Knee (knee injection to be done in office)

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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 11/13/09 and 12/23/09

Anesthesia and Pain Services

8/11/09 thru 10/29/09

MRI 8/25/09, 8/26/09

Diagnostic 10/13/09, 9/21/09

Injury & Rehab 7/2/09, FCE 8/26/09

Neuro-Diagnostics 10/19/09, 9/17/09

OP Report 9/18/09

Dr. 7/8/09 thru 10/22/09

Dr. 9/4/09 thru 12/4/09

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured x/xx/xx. He had neck and low back pain and knee pain. The pain went into both upper extremities with paresthesias in the right hand. He had some relief with a lumbar ESI. The cervical MRI showed a disc bulge at C3/4 and a left central herniation at C7/T1. The EMG showed some spontaneous activity in the right brachioradialis and both deltoid muscles, and the paraspinal muscles consistent with C5/6 radiculopathy.

Dr. described medial left knee tenderness with good motion. Dr. felt there was a bruise. None of the doctors described any effusion. Pain limited knee motion.

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

The first consideration is the cervical epidural injection. This requires a dermatomal distribution with confirmation. The MRI findings are consistent with a disc herniation at C7/T1 but do not explain the C5 emg abnormalities. There was no dermatomal description of the pain. The ODG does consider the role of a diagnostic block when there is an inconsistency. The request is for a therapeutic block, which requires dermatomal pain symptoms, and this was not provided.

The second point for consideration is the role of a long acting corticosteroid injection for the knee pain. This is approved in the management of osteoarthritis of the knee, a diagnosis that has not established. The pain appears along the medial knee, but the reviewer could not determine if it was due to the joint itself (normal MRI), or a bursitis in the pes region or along the medial collateral ligament. There was no description of a traumatic synovitis. The only diagnosis posed was a bruise. The latter would not meet the requirements for a corticosteroid injection. Since the pain generator has not been determined, and osteoarthritis has not been documented clinically or radiologically, the reviewer cannot justify the medical necessity of a corticosteroid injection at this time.

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 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)