

SENT VIA EMAIL OR FAX ON
Jan/08/2010

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/08/2010

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) (in

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 12/3/09, 12/11/09, 12/15/09

12/3/09 and 12/14/09

Pain Institute 9/30/09 thru 12/8/09; OP Reports 11/12/09 and 10/21/09

DDE 6/8/09

X-Rays 5/7/08 and 10/10/08

Upper Extremity Eval 5/29/09

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured on x/xx/xx. He subsequently underwent an anterior fusion at C4/5/6 in 10/08 in the DD exam. This was not provided in Cr. records. He continued to have neck pain and pain along the C5/6 dermatome per Dr. An EMG reportedly showed bilateral C5/6/7 radiculopathy. The man underwent C7/T1 ESIs on 10/21/09 and 11/12/09 with 60-70% relief that reportedly lasted 6 days. The relief fell to 20% at 12/1; 18 days post the second procedure. Dr now wished to perform a third ESI.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

Dr. stated he would only perform the ESIs under the ODG criteria. The ODG does not permit a series of 3. Dr. noted in his notes that the purpose of the injection is for control of the C5/6 pain for the two prior injections. Repeat therapeutic ESIs are not permitted unless there was at least 50% improvement for at least 6 weeks. The relief here had been for less than 3 weeks. Although the man remains symptomatic, he has not met the ODG requirements for a third ESI.

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)