

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 11/22/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Transforaminal Steroid Injection Lt C6-7 under fluoroscopy

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the Transforaminal Steroid Injection Lt C6-7 under fluoroscopy is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 11/12/10

- Letter of determination – 10/04/10, 11/01/10
- Letter to – 11/12/10
- Office visit notes by Dr. – 03/05/10 to 09/29/10
- Procedure note by Dr. – 08/18/10
- Consultation by Dr. – 08/17/10
- Orthopedic report by Dr. – 05/24/10
- Initial examination by Dr. – 03/29/10
- Report of MRI of the cervical spine – 04/23/10
- Report of nerve conduction study – 03/29/10
- Workers Compensation Progress Report – 02/02/10
- Electrodiagnostic testing by Dr. – 10/27/09
- Copy of ODG Integrated Treatment/Disability Duration Guidelines – 08/05/10

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was involved in a fight. This resulted in pain to the posterolateral upper back, neck and left shoulder. He also complains of numbness and tingling to the left upper extremity. He has been treated with medications, physical therapy and left shoulder surgery including subacromial decompression and Mumford procedure on 03/16/09. He has undergone C6-7 transforaminal steroid injection on 08/18/10. Relief of symptoms for a short period of time was achieved. The treating physician has recommended that the patient undergo a repeat left C6-7 transforaminal steroid injection under fluoroscopy.

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

This patient reported relief of symptoms for only a few days after the injections of 08/18/10. This type of very short term relief is insufficient to justify repeat epidural steroid injections. It would appear that this patient has had benefit from a recent change in medication and this regimen of treatment should probably be continued. There is insufficient medical record documentation of benefit from the original epidural steroid injection to justify its repeat at this time.

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)