

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: NOVEMBER 16, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed outpatient Lumbar Epidural steroid injection at L4/5 on right with catheter and saline

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
unk	outpatient Lumbar Epidural steroid injection at L4/5 on right with catheter and saline		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-16 pages

Respondent records- a total of 13 pages of records received to include but not limited to:
 TDI letter 10.27.10; Dr. records 9.8.10, 9.23.10; MRI Lumbar spine 8.5.10; Emergency Center records, 8.6.10; DWC form 73 8.3.10, 8.6.10; Pain Management 9.8.10

Requestor records- a total of 13 pages of records received to include but not limited to:
 PHMO Notice of IRO assignment; MRI Lumbar spine 8.5.10; Emergency Center records, 8.6.10; DWC form 73 8.3.10, 8.6.10; Pain Management 9.8.10

PATIENT CLINICAL HISTORY [SUMMARY]:

Clinical History: The medical records presented for review begin with a lumbar MRI dated August 5, 2010 and noted an L5-S1 disc herniation with annular tearing and a lateral recess stenosis. There was also an L3-4 foraminal stenosis.

Subsequent to this, Dr. completed a pain management consultation, noting the history of hypertension. The suggestion was to do an L4-5 epidural steroid injections and a TENs unit. It would appear that this was non-certified and on September 23, 2010, Dr. wrote a letter of medical necessity. It was noted that more conservative therapies had been tried and were not effective.

Dr. has non-certified this request as there was no radicular component to this clinical situation and that the MRI did not objectify that there was a nerve root compression among the reasons for not-certifying this request. On appeal Dr. Wilson also non-certified this request

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC’S POLICIES/GUIDLEINES OR THE NETWORK’S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines the first issue is that “radiculopathy must be documented.” There is no competent, objective and independently confirmable medical evidence of a verifiable radiculopathy noted in the records presented for review. The MRI does not note any lesion that would be causative of a verifiable radiculopathy. Further, with the restriction to the involved level, the requested site is caudal to the lesion noted. This request is simply not supported by the clinical data presented.

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

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES