

Notice of Independent Review Decision
IRO REVIEWER REPORT

DATE OF REVIEW: 03/31/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Transforaminal cervical epidural steroid injection on right C3-4 and C4-5

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 neurosurgeon 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 cervical epidural steroid injection on right C3-4 and C4-5 are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 03/22/XX
- Decision letter – 02/04/XX, 02/23/XX
- Work Comp Verification for Diagnostic/Surgical Procedures – 01/20/XX
- Office visit notes by Dr.– 06/10/XX to 02/10/XX
- Operative note by Dr.– 08/17/XX
- Physical therapy daily progress notes – 11/16/XX to 02/07/XX
- Peer Review Report– 02/02/XX, 02/21/XX
- Report of MRI of the right shoulder – 06/28/XX

PATIENT CLINICAL HISTORY [SUMMARY]: This injured worker sustained a work-related injury on XX/XX/XX resulting in pain to her neck with radiation into

her right shoulder, head and right arm. Her pain was described as 7/10 on a pain scale. She also has right arm and hand numbness. She is status post cervical fusion on 01/03/XX and carpal tunnel surgery in 19XX. The patient has been treated with medications, physical therapy and transforaminal injections at C3-C4 and C4-C5 on the right. There is a request by the treating physician for transforaminal cervical epidural steroid Injections at C3-4 and C4-5 on the right.

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

This patient underwent an epidural steroid injection on 08/17/XX and was seen twice on follow up on 10/14/XX and 10/27/XX. There is no mention of the efficacy of the epidural steroid injections other than an indirect inference that the symptoms persisted at the time of the visit. There would be no indication for additional injections without documentation of the patient's response to the first injections.

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)