

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 01/06/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

62310 Injection, w/wo contrast; diagnostic/therapeutic
72275 Epidurogram

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

The TMF physician reviewer is board certified in pain management 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 62310 Injection, w/wo contrast; diagnostic/therapeutic and 72275 Epidurogram are medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 12/21/11
- Adverse Determination Letter from– 11/15/11, 12/01/11
- Report of Medical Evaluation by – 11/29/11
- MMI Report by – 11/29/11

- Impairment Rating by– 11/29/11
- Pre-Certification Form for Injection by – no date
- Follow Up Report by – 11/08/11, 12/16/11
- Report of MRI of the cervical spine – 10/06/11
- Report of Electrodiagnostic Results – 10/17/11
- Office visit notes by – 10/11/11
- Initial Consultation by – 09/27/11
- Report of thoracic spine radiography – 09/26/11

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when a counter fell and struck her on the back of the neck. The patient complains of pain that is rated as 4-7 out of 10 with positive numbness in the left upper extremities. She has been treated with analgesics, muscle relaxants and a home exercise program. There is now a request for an epidural steroid injection at C5-C6.

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

The ODG Guidelines have been met for the approval of this procedure. There is documented evidence of failed physical therapy and medications; evidence of radiculopathy by abnormal EMG's and a correlation of MRI results with the patient's symptoms that include HNP at vertebra left C5-6.

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)