

INDEPENDENT REVIEW INCORPORATED



SENT TO: Texas Department of Insurance
Health & Workers' Compensation Network Certification & QA
Division (HWCN) MC 103-5A
512.804.4868

January 30, 2007

RE: IRO Case #: M2 07 0445 01
Name: _____
Coverage Type: Workers' Compensation Health Care - Non-network
Type of Review:
 Preauthorization
 Concurrent Review
 Retrospective Review
Prevailing Party:
 Requestor
 Carrier

Independent Review, Inc. (IRI) has been certified, IRO Certificate # 5055, by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to IRI for independent review in accordance with the Texas Insurance Code, the Texas Labor Code and applicable regulations.

IRI has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, IRI reviewed the medical records and documentation provided to IRI by involved parties.

This case was reviewed by an orthopedic surgeon. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), and any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.


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As an officer of IRI, I certify that:

1. there is no known conflict between the reviewer, IRI and/or any officer/employee of IRI with any person or entity that is a party to the dispute, and
2. a copy of this IRO decision was sent to all of the parties via U.S. Postal service or otherwise transmitted in the manner indicated above on January 30, 2007.

RIGHT TO APPEAL:

You have the right to appeal the decision by seeking judicial review. This IRO decision is binding during the appeal process.

For disputes other than those related to prospective or concurrent review of spinal surgery, the appeal must be filed:

1. directly with a district court in Travis County (see Labor Code 413.031(m)), and
2. within thirty (30) days after the date on which the decision is received by the appealing party.

For disputes related to prospective or concurrent review of spinal surgery, you may appeal the IRO decision by requesting a Contested Case Hearing (CCH). A request for CCH must be in writing and received by the Division of the Workers' Compensation, Division Chief Clerk, within ten (10) days of your receipt of this decision.

Sincerely,

Jeff Cunningham, D.C.
Director of Operations

**REVIEWER'S REPORT
M2 07 0445 01**

DATE OF REVIEW: 01/29/07

IRO CASE #: M2-07-0445-01

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

A ganglion of impar block as well as atlantoaxial and atlantooccipital joint injections with fluoroscopy have been denied as medically unnecessary.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

Extensive medical documentation both from the requestor and provider measuring greater than 3 inches were reviewed.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The claimant was involved in a severe motor vehicle accident in which he was rear-ended on _____. He was in a coma and suffered multiple injuries including low back, coccygeal injuries, scalp lacerations, facial injuries, head trauma, neck trauma, and left shoulder trauma. As expected, he has gone on to have chronic pain. A ganglion of impar block for coccydynia as well as atlantoaxial and atlantooccipital joint injection with fluoroscopy has been denied as medically unnecessary.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

This patient has chronic coccydynia that has been refractory to conservative treatment. In addition, he has chronic neck pain at the atlantoaxial and atlantooccipital joints. Steroid injections into both of these joints would be reasonable treatment as a favorable

alternative to arthrodesis at those joints. In addition, a ganglion impar block has been denied by the insurance carrier as having no medical basis. There is a good article in the American Journal of Physical Medicine and Rehabilitation in 2006 by Foye Buttaci, et al, describing successful ganglion impar blocks for coccyx pain. This is a peer review journal. I believe all of these 3 injections are medically necessary for this patient and should be approved.

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

(Check any of the following that were used in the course of your review.)

- 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)