

Notice of Independent Review Decision

DATE OF REVIEW: 12/18/2007
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

64483: Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level
64484: Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level
(List separately in addition to code for primary procedure)

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from University of Tennessee, College of Medicine and completed training in Orthopedics at Vanderbilt University Hospital. He completed a General Surgery Residency at University of California, San Diego. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Orthopedics since 9/14/1973 and currently resides in TX.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

<input checked="" type="checkbox"/> Upheld	(Agree)
<input type="checkbox"/> Overturned	(Disagree)
<input type="checkbox"/> Partially Overturned	(Agree in part/Disagree in part)

64483: Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level Upheld
64484: Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level
(List separately in addition to code for primary procedure) Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Review organization note dated 12/11/2007
2. Clinical note by MD dated 12/10/2007
3. Request form dated 12/8/2007
4. Notice of utilization review dated 10/31/2007
5. Notice of utilization review dated 11/28/2007
6. Reviews of case assignment by dated 12/11/2007
7. Clinical note dated 12/12/2007
8. Review organization by, dated 12/11/2007
9. Clinical note dated 12/12/2007
10. Independent review organization dated 12/8/2007
11. Notice of utilization review dated 10/31/2007
12. Clinical note dated 10/25/2007
13. Clinical note dated 10/17/2007
14. Clinical note dated 4/17/2007
15. Clinical note dated 2/13/2007
16. Clinical note dated 1/16/2007
17. Clinical note by MD, dated 12/12/2006
18. Clinical note dated 12/12/2007
19. Notice of utilization review dated 11/28/2007
20. Clinical note dated 11/28/2007
21. Clinical note dated 11/20/2007
22. Clinical note dated 12/12/2007
23. Clinical note by MD, dated 12/12/2006
24. Clinical note dated 11/19/2007
25. Clinical note dated 10/17/2007
26. Clinical note dated 4/17/2007

27. Clinical note dated 2/13/2007
28. Clinical note dated 1/16/2007
29. Notice of assignment by, dated 12/11/2007
30. IRO request form dated 12/11/2007
31. Clinical note dated 12/10/2007
32. Request form dated 12/8/2007
33. Notice of utilization dated 10/31/2007
34. UB form dated 6/25/2007
35. Final report dated 6/28/2007
36. Review findings dated 4/27/2007
37. Clinical note by MD, dated 6/25/2007
38. Post operative orders by MD, dated 7/20/2007
39. Clinical note dated 4/17/2007
40. MRI lumbar spine by MD, dated 12/12/2006
41. Notice of utilization review dated
42. Clinical note dated 2/13/2007
43. Clinical note dated 3/14/2007
44. Clinical note by MD, dated 2/8/2007
45. Post operative orders by MD, dated 2/24/2007
46. Clinical note dated 1/16/2007
47. Clinical note by MD, dated 12/5/2006
48. Clinical note dated 10/3/2006
49. Clinical note dated 7/6/2006
50. Intake assessment and report by MA, dated 11/1/2006
51. Overview of the psychophysiological assessment by MA, dated 11/1/2006
52. The ODG Guidelines were not provided

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a xx year old male with thoracic/lumbar disc displacement, lumbago, and lumbosacral neuritis. He sustained an injury while moving cable barrels from pallet to another pallet on xx/xx/xx. An MRI from 12/12/2006 indicated a disc bulge at L4-5 with a superimposed small left subarticular herniation. There was evidence of right and left foraminal narrowing and a disc bulge at L4-S1 with superimposed right subarticular herniation. Bilateral narrowing was also noted at this level. The injured employee was noted to be last seen on 11/19/2007 for complaints of lower back pain and lower extremity pain.

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

On 10/17/2007 Dr. noted physical findings "SLR: left: positive at L4-5, L5-S1 with diminished sensation and diminished strength." He recommended a third injection and referenced supporting articles from 2004-2005 from Dr.

The ODG 2007, 5th Edition, under Lumbar Spine treatment summary provides criteria for the use of epidural steroid injections (ESI). Number 9 states "current research does not support a routine use of series-of-three injections in either the diagnostic or therapeutic stage. We recommend no more than 2 ESI injection for the initial phase and rarely more than 2 injections for therapeutic treatment."

Moreover, the physical findings noted on 10/17/2007 are vague, non-dermatomal, and inconsistent with the required "dermatomal distribution with corroborative findings of radiculopathy" as required by ODG. They describe diminished sensation and strength, but the language is general and not consistent with objective, unequivocal evidence of radiculopathy. A lumbar MRI from 2006 demonstrated subarticular left herniation at L4-5, and EMG demonstrated no sign of radiculopathy.

In summary, the records do not provide objective clinical, or even electrodiagnostic, evidence of radiculopathy as required by ODG when considering ESIs. Moreover the request for a third ESI is not consistent with ODG guidelines which do not recommend more than two injections. The ODG further states under "use for chronic pain: chronic duration of symptoms (> 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months. The ideal time of either when to initiate treatment or when treatment is no longer thought to be effective has not been determined."

Therefore, the previous denial is upheld.

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

X 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)