

IRO Reviewer Report

DATE OF REVIEW: 03/08/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

64483 injection foramen epidural L/s
64484 injection foramen epidural add
76005 fluoroguide for spinal injection

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

Board certified in anesthesia and pain management, on the TDI-WC approved doctor's list, 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 proposed 64483 injection foramen epidural L/s, 64484 injection foramen epidural add, and 76005 fluoroguide for spinal injection are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Information provided by the requestor:

None

Information provided by the respondent:

- Position statement– 02/26/07
- Required Medical Examination by Dr. – 01/25/06
- Expert Review by Dr. – 11/17/06
- Request for Procedure – 12/06/06
- Results of MRI of the lumbar spine – 11/29/04
- Office notes from MD -09/20/06 to 11/29/06
- Clinic notes by Dr. – 11/02/05
- Decision letter – 12/12/06, 01/03/07
- PEER review 12/11/06, 01/02/2007
- Appeal from Dr. – 12/20/06, 12/28/06

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on when he tripped over some cables that were left out of place on the floor, and he landed on his left knee and elbow. This resulted in injury to his left knee, left elbow, and lumbar spine. The patient has been treated with monthly epidural steroid injections as well as physical therapy including a home exercise program.

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

The medical record documentation does not support the proposed procedure. There are no documented confirmations of radiculopathy, sensory, or reflex alterations. The MRI indicates no new pathology. The body of the MRI report states no substantial changes noted since the previous MRI performed in 2002. Since there is no significant changes noted, then the patient's pain would be related to an exacerbation of an underlying condition, not a new problem. In view of the MRI report, it is unlikely that the condition requires. Transforaminal epidurals are not designed for the breaking up of scar tissue or adhesions and are intended for target specific steroid placement. Lyses of adhesions are performed with epduroscopy or hypertonic saline 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

X 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)

Pain Physician, Jan 2005, Interventional Techniques in Management of Chronic Spinal Pain: Evidenced Based Practice Guidelines.