



PROFESSIONAL ASSOCIATES

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 03/20/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

TFESI (64483, 64486), fluoroscopy (76005), MAC anesthesia (01992), and J codes

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

Board Certified in Anesthesiology
Fellowship Trained in Pain Management
Added Qualifications in Pain Medicine

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with D.O. dated 10/27/06, 11/02/06, 11/09/06, 11/20/06, 11/30/06, and 12/11/06

Physical therapy with M.P.T. dated 10/31/06, 11/01/06, 11/02/06, 11/07/06, 11/08/06, and 11/09/06

An MRI of the lumbar spine interpreted by M.D. dated 11/28/06

An evaluation with M.D. dated 01/15/07

A letter of non-authorization from L.V.N. dated 01/18/07

An evaluation with M.D. dated 01/18/07

Letters of non-authorization from dated 01/23/07 and 02/09/07

An evaluation by P.T. dated 01/23/07

A letter of reconsideration from Dr. dated 01/30/07

A letter of non-authorization from M.D. dated 02/07/07

Physical therapy with Mr. dated 02/13/07

An evaluation with P.A.-C. for Dr. dated 02/15/07

A letter of necessity from Dr. dated 02/19/07

PATIENT CLINICAL HISTORY [SUMMARY]:

On 10/27/06, Dr. recommended Motrin, Flexeril, physical therapy, a home exercise program, lumbar support, and modified work duty. Physical therapy was performed with Ms. from 10/31/06 through 11/09/06 for a total of six sessions. On 11/20/06, Dr. ordered an MRI of the lumbosacral spine and continued the patient on Darvocet, Flexeril, and an unknown medication. An MRI of the lumbar spine interpreted by Dr. on 11/28/06 revealed a large disc herniation at L1-L2 and diffuse disc bulging with stenosis at L4-L5 and L5-S1. On 11/30/06, Dr. referred the patient to a spine specialist and pain management specialist. On 01/15/07, Dr. recommended an epidural steroid injection (ESI). On 01/18/07, Ms. wrote a letter of non-authorization for the ESI. On 01/18/07, Dr. recommended aquatic therapy, Skelaxin, Lortab, Motrin, and injections. On 01/23/07 and 02/09/07, wrote letters of non-authorization for the ESI. On 01/30/07, Dr. wrote a letter of reconsideration for the ESI. Dr. wrote a letter of non-authorization for the ESI on 02/07/07. Physical therapy was performed with Mr. on 02/13/07. On 02/19/07, Dr. wrote a letter of medical necessity for the ESI.

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

Although the MRI scan does demonstrate evidence of a focal left disc herniation at L1-L2 affecting the L2 nerve root, the patient's subjective complaints do not correlate with such a finding nor does any physical examination evidence provided by either Dr. or any other physician correlate with this MRI scan finding. A positive straight leg raising test has nothing whatsoever to do with the L2 nerve

root and does not provide justification for the requested transforaminal epidural steroid injections above and below the L1-L2 disc herniation. Moreover, there is no medical justification or necessity whatsoever for performing transforaminal epidural steroid injection at any level other than the level where the disc herniation is noted nor is there is any indication for performing bilateral transforaminal epidural steroid injection when the patient's pain is only unilateral and there are only unilateral MRI findings. It appears that Dr.'s request is based solely upon the MRI findings, although there is, in fact, no justification for requesting transforaminal epidural steroid injections above and below the L1-L2 disc herniation, which would place the injections at the L2-L3 and T12-L1 levels, neither of which demonstrates any pathology. In other words, the requested procedures would actually be done at non-pathologic, normal levels, not at the only level where pathology was noted. Therefore, absent any objective evidence of pathology above or below the disc herniation as well as any correlation between the MRI findings and the patient's symptoms and physical examination, there is no medical justification, indication, reason, or necessity for transforaminal epidural steroid injections of any type for this patient, certainly not, as requested, above and below the level of the disc herniation. Additionally, the preponderance of physical examination evidence presented with this case fails to demonstrate evidence of radiculopathy, regardless of the MRI scan findings. Epidural steroid injections are indicated for treatment of radicular pain correlating with objective evidence of structural pathology only. In this case, the patient's subjective complaints and physical examination do not constitute true radiculopathy, nor do they correlate with the MRI finding of left L1-L2 disc herniation and L2 nerve root compromise. Therefore, although the MRI scan does demonstrate a structural abnormality, that abnormality does not correlate at all with the patient's clinical condition or clinical presentation and, therefore, it does not provide any justification, indication, reason, or necessity for transforaminal epidural steroid injection. The non-authorization of Dr.'s request, therefore, is appropriate and should be 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 AND KNOWLEDGE BASE**
- 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)