

Notice of Independent Review Decision
REVISED
 Failed to put date on 1st page of decision

REVIEWER'S REPORT

DATE OF REVIEW: 04/30/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
 Bilateral L4/S5 lumbar facet under fluoroscopy with IV sedation #1.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
 M.D., board certified in Anesthesiology by the American Board of Anesthesiology

REVIEW OUTCOME:
 Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
724.5	64470		Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:
 1. TDI case assignment

2. Letters of denial dated 03/10/08 and 04/10/08, criteria used in denial, ODG, and letter of submission dated 04/18/08
3. History and physical and evaluation dated 12/28/07
4. Operative reports, 01/30/08 and 02/27/08
5. Pain Management follow up, 02/29/08
6. Course of treatment exams, lab, and radiologic reports dated 10/30/07 - 03/18/08

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a male with an apparent work-related injury to the lumbar back. The patient reports low back pain radiating into the left buttock and left thigh and knee. This is associated with numbness. The patient has been treated with analgesics, relaxants, and physical therapy. A series of lumbar epidural steroid injections failed to produce improvement. An MRI scan reveals L4/L5 disc tear and bulge with associated neural foraminal narrowing, left greater than right.

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

This patient clearly has a lumbar radiculopathy by history and examination. Radiologic studies demonstrate disc herniation and neural foraminal compromise, which explain examination findings. The carrier's reviews and reconsiderations are appropriate and thorough regarding this patient's clinical circumstance. The ODG and American Society of Interventional Pain Physicians Evidenced-Based Practice Guidelines in the Management of Chronic Spinal Pain are operative in this case. Facet pathology will not address the lumbar radiculopathy and disc herniation.

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

INDEPENDENT REVIEW INCORPORATED

- 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: Pain Physician, 2007, Volume 10, pages 7-111, titled, "Interventional Techniques: Evidenced-Based Practice Guidelines in the Management of Chronic Spinal Pain"
 Other evidence-based, scientifically valid, outcome-focused guidelines