

Notice of Independent Review Decision

DATE OF REVIEW: 1/23/2008
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

64483: Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level
72275: Epidurography, radiological supervision and interpretation
62284: Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)
62282: Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from Texan Tech University Health Sciences Center and completed training in Physical Med & Rehab at University of Texas Health Science Center at San Antonio. 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 Physical Med & Rehab since 7/1/1998.

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)

64483: Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level Upheld
72275: Epidurography, radiological supervision and interpretation Upheld
62284: Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa) Upheld
62282: Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal) Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Notice to air analyses dated 6/8/2008
2. General information dated 1/8/2008
3. Clinical note by RN, dated 1/7/2008
4. Request form dated 1/2/2008
5. Confirmation of receipt dated 1/7/2008
6. IRO request form dated 1/8/2008
7. Clinical note dated 12/7/2007
8. Clinical note by RN, dated 12/21/2007
9. Clinical note dated 01/09/2008
10. Position statement by RN dated 01/09/2008
11. Utilization review by RN dated 12/06/2007
12. Clinical note by RN dated 12/07/2007
13. Utilization review by MD dated 12/21/2007
14. Clinical note by RN dated 01/09/2008

15. Clinical note dated 12/21/2007
16. Clinical note by MD dated 11/08/2006
17. Recommendations dated 06/27/2007
18. Outpatient visit note dated 12/04/2007
19. Outpatient visit note dated 10/01/2007
20. Outpatient visit note dated 08/13/2007
21. Consultation note by MD dated 08/17/2006
22. Outpatient visit note dated 12/04/2007
23. Outpatient visit note dated 10/01/2007
24. Outpatient visit note dated 08/13/2007
25. Consultation note dated 08/17/2006
26. Office visit note dated 12/4/2007
27. Office visit note dated 10/1/2007
28. Office visit note dated 8/13/2007
29. report dated 12/7/07
30. report dated 12/21/07
31. The ODG Guidelines were not provided

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The employee is a female. According to the notes provided, she injured her lower back in a work injury and has been unable to work since that time. MRIs of the lumbar spine performed in 8/2006 and 8/2007 showed a small central disc protrusion at L5-S1 with no evidence of disc herniation, scar tissue, nerve root compression, or stenosis. EMG/NCS studies from 8/2006 were negative. The injured worker has been treated with ESI, transforaminal neuroplasty, physical therapy, work conditioning, NSAIDs, muscle relaxers, and pain medications. At this time, the request for right S1 transforaminal neuroplasty is under review for medical necessity.

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

The Official Disability Guidelines do not support the procedure at this time. Previous injections have only provided temporary relief. There is no medical evidence that the new procedure will be of any long term benefit to treat this chronic condition. Therefore, in accordance with the Official Disability Guidelines, 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
- 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)