I-Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: JULY 19, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Epidural w/ fluoroscopy Lumbar, Injection Trigger Point x 2, 62311, 77003, 72275, 20550, 99144, 99070

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

MD, Board Certified Orthopedic Surgeon
Board Certified in Pain Management

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.

The reviewer finds that medical necessity does not exist for epidural w/ fluoroscopy Lumbar, Injection Trigger Point x 2, 62311, 77003, 72275, 20550, 99144, 99070.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 6/10/08, 5/26/08
ODG Guidelines and Treatment Guidelines
MRI, 6/7/07
, MD, 6/5/08, 4/22/08, 1/31/08, 11/20/07, 10/18/07, 8/28/07, 7/31/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx-year-old male with date of injury more than sixteen years ago. There is note in the medical record of paralysis but no physical examination or further explanation. He complains of chronic back pain and leg pain. He apparently rides in the wheelchair and apparently has spasticity in the legs and back trigger point areas. An MRI scan reveals some broad-based disc bulging and some degenerative change with facet hypertrophy with multilevel mild to moderate stenosis.

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

In this particular patient, while paralysis is mentioned, there is no evidence on the MRI scan for the reason for this. The physical examination does not reflect clinical radiculopathy. The ODG Guidelines concerning epidural steroid injections as well as general medical standards are for documented radiculopathy usually in the acute phase, which is unresponsive to conservative treatment. It can also be used in the diagnostic phase. Obviously this patient is far from the diagnostic phase and far from the acute phase. There has not been any documented objective radicular findings by physical examination in the medical records that were provided. It is for this reason that medical necessity cannot be determined in support of these injections. Furthermore, as far as the trigger point injections are concerned, similar issues apply. In fact, per ODG Guidelines, they are not recommended in a case such as this. There may be evidence of some myofascial complaints that may possibly fall under the ODG Guidelines for trigger point injections. However, the request for the trigger point injections times two without documentation of sufficient pain relief after initial injection would not conform to the Guidelines. Furthermore, if this patient truly has spasticity from some neurological injury in the past that is resulting in these pain complaints, then possibly the use of this particular type of trigger point injection would be, at the very best, temporary. As far as the epidural steroid injections are concerned, once again, the absence of documented radiculopathy and neurological changes do not permit approval of this particular request.

The reviewer finds that medical necessity does not exist for epidural w/ fluoroscopy Lumbar, Injection Trigger Point x 2, 62311, 77003, 72275, 20550, 99144, 99070.

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**
- [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)**