

Notice of Independent Review Decision

DATE OF REVIEW: 09/15/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient bilateral L5/S1 transforaminal epidural steroid injection with fluoroscopy.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in private practice of Pain Management full time since the early 90's

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>
719.53			<i>Prosp</i>						<i>Upheld</i>
723.1			<i>Prosp.</i>						<i>Upheld</i>
842.0			<i>Prosp.</i>						<i>Upheld</i>
847.0			<i>Prosp.</i>						<i>Upheld</i>
847.2			<i>Prosp.</i>						<i>Upheld</i>
719.43			<i>Prosp.</i>						<i>Upheld</i>

INFORMATION PROVIDED FOR REVIEW:

- Letters of denial, 07/10/08, 08/05/08, including criteria for denial (ODG)
- Radiology reports, 10/12/06, 05/16/07
- EMG/NCV study, 03/21/08
- Consultations, progress notes, and reports, 04/15/06 through 06/19/08
- Evaluation and reports, 04/27/07 through 06/18/08

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This individual has persistent low back pain after injury. There is no evidence of radicular pain and no evidence of nerve impingement on MRI scan. There was temporary relief after a second lumbar epidural steroid injection.

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

The ODG criteria are not met since there is no evidence of radiculopathy. The EMG study does not reveal a radiculopathy, and there is no evidence of nerve impingement on MRI scan. In addition, the previous epidural steroid injection provided only transient relief. Therefore, the ODG criteria have not been met.

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

(Check any of the following that were used in the course of your review.)

- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)