

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 08/20/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4-L5 epidural steroid injection with fluoroscopy, epidurogram with anesthesia to include treatment codes #62311, #77003, #72274, #01991.

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

The TMF physician reviewer is board certified in anesthesia/pain management with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the L4-L5 epidural steroid injection with fluoroscopy, epidurogram with anesthesia to include treatment codes #62311, #77003, #72274, #01991 is not medically necessary to treat this patient's condition.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 08/03/09
- Decision letter from – 07/07/09, 07/23/09
- Progress note from – 07/16/09
- History and Physical by Dr. – 06/24/09
- Prescription for pain medication – 07/16/09
- Report of MRI of the lumbar spine – 04/29/09
- Letter to TMF from – 08/04/09
- Report of record review by – 07/06/09, 07/23/09
- Request for pre-certification by Dr. – 07/02/09, 07/20/09
- Examination findings by Dr. – 06/24/09
- Physical performance evaluation – 05/26/09

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when she was at work and hurt her back. She complains of back pain, pain to the right leg with weakness and muscle spasms. She has been treated with chiropractic care, physical therapy and intramuscular steroid injections. The treating physician is recommending that the patient undergo L4-L5 epidural steroid injection with fluoroscopy, epidurogram with anesthesia.

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

The ODG guidelines state that evidence of radiculopathy should be present. The physical examination displays no deficit, the EMG is normal and an MRI shows no impingement. Therefore, the ODG criteria has not been met.

### **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)