

IRO REVIEWER REPORT

DATE OF REVIEW: 02/10/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar epidural steroid injections under fluoroscopy 64483 77003

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

The TMF physician reviewer is a board certified neurosurgeon 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 lumbar epidural steroid injections under fluoroscopy 64483 77003 are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information of requesting a review by an IRO – 02/02/09
- Notification of Determination from – 12/03/08, 12/05/08, 12/22/08
- Specific and Subsequent Medical Reports by Dr. – 02/20/97 to 08/10/00
- Preauthorization by – 12/03/97, 01/15/99, 06/15/99

- Report of cervical myelogram – 12/12/97
- Short office notes by Dr.– 03/30/98 to 08/02/99
- Report of Lumbar CT after discogram – 06/18/99
- Report of myelogram – 01/22/99
- One page of progress note Medical Center – 02/10/99
- History and Physical by Dr. – 06/17/99, 01/31/00
- Two pages from Medical Fee Guidelines – no date
- Operative report by Dr. – 02/01/00, 12/16/03, 12/06/05, 02/13/08
- Operative report by Dr. – 02/01/2/00
- Report of x-rays of the lumbar spine – 02/24/00 to 10/11/02
- Partial Physician's Orders from Hospital – 01/31/00 to 02/02/00
- Discharge Summary from Hospital – 02/02/00
- Letter from Dr. to Dr. – 11/09/00 to, 05/09/05
- Notice of IRO Determination by – 10/28/03
- Center – Pain Clinic record – 10/11/02 to 05/17/05
- Determination of preauthorization from– 09/27/01,09/24/02
- Report of CT myelogram of the lumbar spine – 12/16/03
- Report of lumbar myelogram – 12/16/03
- Letter from Dr. to Dr. – 11/07/05 to 12/11/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx resulting in pain to his lower back from severe L4-5 and L5-S1 disk disease. He has been treated with medications, surgery and epidural steroid injections.

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

The medical record documentation does not document lumbar radiculopathy either subjectively or objectively enough to justify epidural steroid injections. There is no physical examination that documents root tender signs and the most recent radiographic study (myelogram/CT) showed no evidence of neural compromise.

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)