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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 02/04/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Injection/Infusion of neurolytic substance (EG, alcohol, phenol, iced saline solutions), with or without other therapeutic substance, epidural, lumbar, sacral (caudal)

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

Board Certified in Pain Management & Anesthesiology

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.

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

- MRI of the lumbar spine without contrast, M.D., 01/03/08
- Examination Evaluation, M.D. and D.C., 01/17/08, 03/20/08
- Electrodiagnostic Study, D.O., 01/09/08
- MRI of the lumbar spine, M.D., 03/13/08
- Progress Notes, M.D., 11/11/08
- Pre-Authorization, 11/29/08
- Adverse Determination, 12/01/08, 12/31/08
- Letter of Appeal for Lumbar ESI, Dr. 12/19/08
- Appeal, 12/30/08
- Notice to URA of Assignment of IRO, 01/15/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient underwent multiple lumbar MRIs as well as electrodiagnostic studies. On 11/11/08, the patient was seen by Dr., complaining of continuing lumbar pain radiating to the right leg with numbness in the right leg. Physical examination documented decreased strength in all muscles of the right lower extremity. Dr. noted the MRI report demonstrating a left foraminal stenosis. She recommended a lumbar epidural steroid injection.

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

According to ODG treatment guidelines, lumbar epidural steroid injection is medically reasonable and necessary when there is radiologic imaging evidence of disc herniation causing nerve root compromise or compression which is supported by either EMG or physical examination evidence of radiculopathy, as well as a dermatomal pain distribution corroborated by the MRI findings. In this case, none of those criteria is, or has ever been, met.

This patient complains of RIGHT lower extremity pain and numbness, yet the MRI clearly demonstrates only LEFT foraminal stenosis. The physical examination, similarly, is of findings involving the contralateral leg. The EMG study was entirely normal. Therefore, there is no medical reason, necessity, indication or support in ODG treatment guidelines for this patient to undergo any lumbar epidural steroid injection. There is also no medical reason or necessity for this patient to undergo an injection or infusion of neurolytic substance with or without other therapeutic substances in the lumbar epidural space for the exact same reasons, as well as the fact that there is no medical reason or necessity to perform neurolytic epidural injection for unsubstantiated, non-corroborated lower extremity pain complaints. Therefore, the non-authorization for the procedures requested on this patient is upheld. There is absolutely no medical reason, necessity,

indication, or ODG treatment guideline support for any requested procedure on this patient, much less any interventional treatment whatsoever.

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)**