

Notice of Independent Review Decision

**DATE OF REVIEW:** 03/17/09

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Thoracic epidural steroid injection with fluoroscopic guide\_localization (64470, 64472, 77003)

**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>
	64470		Prosp.		01/19 – 02/19/09 & 01/26 – 02/28/09				Upheld
	64472		Prosp.		01/19 – 02/19/09 & 01/26 – 02/28/09				Upheld
	77003		Prosp.		01/26 – 02/26/09				Upheld

**INFORMATION PROVIDED FOR REVIEW:**

1. Case assignment.
2. Letters of denial 01/23 & 01/30/2009, including criteria used in denial.
3. Medical evaluations 01/21 & 01/30/2009.
4. Pain management evaluation and follow up 08/12, 09/05, 09/12, 09/19, 11/07/2008 and 01/16, 02/06, 02/17/2009.
5. Radiology reports 2008:

2/27 Tomography of thoracic spine  
3/10 Tomography of lumbar spine  
4/12 MRIs of thoracic and lumbar spine

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This male suffered a work-related injury on xx/xx/xx that has resulted in persistent mid-thoracic back, most recently rated 0-4 on VAS. There was also low back pain that has been treated with radiofrequency rhizotomy on 09/05/08. Physical therapy and medications (Ultract, Skelaxin, Neurontin, Methadone & Lidoderm Patches) have also been utilized.

Treating doctor's note of 02/17/09 office visit reported improved pain control with current regimen. Patient was to advance to a home exercise program.

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

The ODG Guidelines state that radiculopathy should be demonstrated to approve an epidural steroid injection. This individual has axial pain with no evidence or documentation of radiculopathy. Therefore, the ODG Guidelines have not been met.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THIS 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 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.)