



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 10/13/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an ESI at L3/4 and L4/5 (62311 & 77003).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation, Pain Management, and Electrodiagnostic Medicine. This reviewer has been practicing for greater than 20 years and performs this type of service in his office.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of an ESI at L3/4 and L4/5 (62311 & 77003).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from MD: Office Notes – 8/5/09-9/15/09; Pain Management letter – 9/9/09, Pre-Certification request – 8/5/09, Reconsideration Request – 8/31/09, Patient Referral Form – 7/27/09; Denial Rational Letter – 8/11/09 & 9/8/09; MD report – 7/23/09; MD CT Lumbar Spine Post Myelogram report – 6/25/09.

Records reviewed from: Denial letter – 8/12/09 & 9/9/09; Pre-authorization request – 8/5/09; Pain Management TWCC WC Form – 8/5/09 & 8/20/09; MD Office Notes – 7/23/09.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured on xx/xx/xx resulting in a lumbar spine fusion with hardware from L3-S1. In spite of surgical interventions, Fentanyl intraspinal medical pump and medications including Roxicodone, Robaxin, Oxycontin and Welbutrin, the patient's pain and disability levels have remained high. Physical examination findings have indicated lumbar muscular spasm, limited lumbar ROM in flexion, extension, and rotation. SLR reported as positive. He has decreased sensation in the leg. DTR reported as abnormal. The patient is unable to heel toe walk secondary to pain. Recent imaging does not indicate any surgical recommendation. The treating doctor, Dr., referred the patient to Dr. for consideration of therapeutic ESI's.

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

According to the ODG: Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

(1) Radiculopathy must be documented. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.

The reviewer states that the medical information provided for this review fails to establish the presence of "unequivocal evidence of radiculopathy." Therefore, the proposed treatment is not medically necessary.

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)**