

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: August 4, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar epidural injection, L4-5; CPT Codes: 62311, 77003, 72275 and 62264.

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

DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Carrier include:

- Texas Workers' Compensation Work Status Report, 01/06/10, 01/29/10, 03/22/10, 04/23/10, 05/06/10, 05/21/10, 06/04/10, 06/21/10
- , M.D., 01/06/10, 03/22/10, 04/23/10, 05/21/10, 06/04/10
- Pain and Recovery Clinic, 01/08/10, 01/11/10, 01/13/10, 01/14/10, 01/15/10, 01/19/10, 01/20/10, 01/21/10, 01/22/10, 01/25/10, 01/26/10, 01/28/10, 02/02/10, 02/03/10, 02/04/10, 02/05/10, 02/12/10, 02/17/10, 02/19/10, 02/22/10, 02/26/10, 03/02/10, 03/03/10, 03/04/10, 03/11/10, 03/15/10, 03/16/10, 03/17/10, 03/25/10, 03/29/10, 03/30/10, 04/01/10, 03/24/10, 03/24/10, 04/21/10, 04/23/10
- EMS Prescription and Statement of Medical Necessity, 01/27/10
- Fitting and Patient Acceptance Form, 01/27/10
- Orthopedics, 01/29/10, 05/06/10
- Therapy and Diagnostics, 01/29/10
- M.D., P.A., 02/01/10, 03/09/10
- M.D., 02/02/10
- MRI and Diagnostic, Inc., 03/18/10
- Neurology, 03/31/10
- MRI, L.L.C., 04/13/10
- Ms., 05/05/10
- M.D., 05/06/10
- Functional Testing, 05/21/10
- Imaging Center, 06/02/10
- TWCC Statement for Pharmacy Services, 03/30/10
- Health Insurance Claim Form, 03/05/10, 05/27/10
- EMS, 04/30/10

Medical records from the URA include:

- Official Disability Guidelines, 2008
- Orthopedics, 01/29/10, 03/18/10, 05/06/10
- Hospital, 12/31/09
- Therapy and Diagnostics, 01/29/10, 03/18/10

- M.D., 02/02/10
- MRI, L.L.C., 04/13/10
- , 05/12/10

Medical records from the Requestor/Provider include:

- Hospital, 12/31/09
- M.D., 01/06/10
- Orthopedics, 01/29/10, 03/18/10, 05/06/10, 06/21/10
- Therapy and Diagnostics, 01/29/10, 03/18/10, 06/21/10
- M.D., 02/02/10
- MRI and Diagnostics, Inc., 03/02/10, 03/18/10
- MRI, L.L.C., 04/13/10
- , 05/12/10, 05/17/10, 05/18/10
- Imaging Center, 06/02/10
- , 06/17/10
- Request for a Review by an Independent Review Organization, 05/26/10

PATIENT CLINICAL HISTORY:

The date of injury is xx/xx/xx. The denial was overturned. The patient as a result of his injury complains of weakness and numbness into the left lower extremity with pain to the left anterior thigh and knee.

The patient had MRI findings that are somewhat ambiguous. However, at level L3-4, there were findings consistent with mild-to-moderate neuroforaminal narrowing bilaterally.

An EMG/nerve conduction study was consistent with findings suggestive of L4-5, left, radiculopathic process.

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

The ODG Guidelines allow epidural steroid injections as “a diagnostic phase.” The additional indications include: 1) Documented radiculopathy. 2) Option for short-term relief of radiculopathy. 3) It helps determination of radiculopathic pain in cases where diagnostic testing is ambiguous. 4) It helps to evaluate a pain generator where physical signs and symptoms differ from that found on imaging studies. 5) It helps to determine pain generators when there is evidence of multilevel nerve root compression. 6) It helps to determine pain generators when clinical findings are consistent with radiculopathy, e.g., dermatomal distribution, but imaging studies are inconclusive. This case meets those findings as set out by ODG Guidelines.

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)