

SENT VIA EMAIL OR FAX ON
Feb/09/2011

True Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 276-1904
Email: rm@trueresolutionsinc.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Feb/08/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left lumbar L4/5 transforaminal ESI with fluoroscopy and monitored anesthesia care

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

The patient is a xx-year-old male whose date of injury is xx/xx/xx. The mechanism of injury is described as bending at work. The patient complains of back and leg pain. He is status post-lumbar surgery on 06/02/10 with laminotomy with partial facetectomy, foraminotomy and neural decompression at L4-5 and L5-S1. MRI of lumbar spine performed on 07/16/10 reported postsurgical changes with left hemilaminectomies at L4 and L5 vertebral levels with microdiscectomies along the left lateral aspects. There is extensive granulation tissue identified without evidence of focal recurrent disc protrusion. There is slight mass effect on posterolateral thecal sac and exiting neural foramina at level of surgery secondary to granulation tissue. Postoperatively the claimant continues to complain of low back pain and left leg symptoms. He underwent left L4-5 and L5-S1 transforaminal epidural steroid injection on 09/27/10. Office note dated 10/12/10 noted the patient underwent transforaminal injection on 09/27/10 at left L4 and L5 nerves, and anesthetic blockade produced complete relief of the patient's usual pain. The patient had positive steroid response with 50+% relief of symptoms

with relief lasting to date. Current relief was reported as 40%.

A request for left lumbar L4, L5 transforaminal epidural steroid injection with fluoroscopy and monitored anesthesia care CPT codes 64483, 64484, 77003, 01991, and 01992 was reviewed by Dr. on 12/08/10. Dr. noted that the patient appeared to satisfy ODG treatment criteria for lumbar epidural steroid injection, with objective physical evidence of lumbar radiculopathy in form of positive straight leg raise and dermatomal hypoesthesia. The patient was noted to have undergone previous epidural steroid injection over 2 months ago with greater than 50% pain relief with pain only now starting to return. The patient has undergone appropriate initial conservative treatment without benefit. Dr. noted the only aspect of the request that cannot be approved is the inclusion of CPT codes 01991 and 01992 which are mutually exclusive. More to the point, Dr. noted neither should be considered medically necessary as services for anesthesiologist or CRNA for MAC anesthesia is only needed when deep sedation or general anesthesia is necessary or when the patient's physical or psychological condition is so tenuous as to require this level of care, which does not seem to be the case here. Dr. further noted that epidural steroid injections can and usually are done without any sedation, since with careful infiltration of local anesthetic they are minimally uncomfortable.

A reconsideration / appeal request was reviewed by Dr. on 12/27/10. Dr. concluded the transforaminal epidural steroid injection is reasonable as the patient has radicular findings on exam and did well for 3 months with the previous injection. However, MAC anesthesia 01991 and 01992 are not supported. It was noted that the patient required only a small amount of Versed at last injection. Dr. further noted that there were two anesthesia codes submitted, one for prone injection (01991) and the other for supine injection (01992) so only 01992 would even be considered in this case. Dr. concluded the request for left lumbar L4, L5 transforaminal epidural steroid injection with fluoroscopy is medically necessary, but monitored anesthesia care is not medically necessary.

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

Based on the clinical information provided, the request for transforaminal epidural steroid injection with fluoroscopy left L4, L5 and monitored anesthesia care is not recommended as medically necessary. The patient is noted to have obtained appropriate benefit from previous transforaminal epidural steroid injection performed on 09/27/10 with anesthetic effect providing complete relief and steroid effect providing at least 3 months of greater than 50% relief. As such, repeat transforaminal epidural steroid injection is indicated as medically necessary as determined on previous reviews. However, there is no medical necessity for monitored anesthesia care. It was noted the claimant only required a small amount of Versed with initial procedure (local conscious IV sedation noted). Epidural steroid injections can and generally are done without necessity of this level of deep sedation and medical necessity is not established.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)