

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 11/02/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Epidural Steroid Injection w/catheter and saline, 62282, 62319, 62284, 72275

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

The TMF physician reviewer is board certified in anesthesia/pain management with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the Lumbar Epidural Steroid Injection w/catheter and saline, 62282, 62319, 62284, 72275 are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 10/21/11
- Decision letter – 09/16/11, 09/29/11
- Request letter from Dr. for epidural steroid injection – 09/21/11

- Progress notes from Dr. – 04/26/11 to 09/12/11
- Operative report by Dr. for epidural steroid injections – 10/05/10
- Operative report by Dr. for epidurogram – 10/05/10
- Report of MRI of the lumbar spine – 03/13/02
- Response to Rebuttal to Peer Review by Dr. – 04/07/11
- Request letters from Dr. for current treatment – 03/29/11 to 06/07/11

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he slipped and fell injuring his lower back. The patient continues to complain of worsening back pain and radiculopathy. Conservative modalities including physical therapy, biofeedback and medications have been used and there is a request for the patient to undergo epidural steroid injections.

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

This injured worker had an epidural steroid injection (ESI) performed on 10/05/10. The office visit notes of 04/26/11 state that there is a return of pain. However, there is no mention of the duration of pain relief or the percentage of relief provided by the previous ESI. The ODG require a 50-70% pain relief for 6-8 weeks in order to repeat an ESI. There is no documentation of this requirement and therefore the ODG criteria have not been met.

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)