

Notice of Independent Review Decision

January 16, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inject Spine L/S 62311; Fluoroguide for Spine Inject 77003; Epidurography 72275; MOD CS by Same Phys 5 Yrs 99144; MOD CS by Same Phys Add-on 99145; Surgical Trays A4550; Surgical Supplies A4649.

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. The physician has been in practice since 1982 and is licensed in Texas and Oklahoma.

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 medical necessity exists for each of the health care services in dispute.

The reviewer finds that the previous adverse determination should be upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records Received: 30 page fax 12/17/12 Texas Department of Insurance IRO request, 7 documents totaling 45 pages received via email 01/07/12 URA response to disputed services including administrative and medical. Dates of documents range from xx/xx/xx (DOI) to 12/17/12

PATIENT CLINICAL HISTORY [SUMMARY]:

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This female was injured originally xx/xx/xx. Since the injury, the patient has had conservative treatment with physical therapy, medication, and the patient has had spinal cord stimulator placement, trigger point injections, and intraspinal myoneural injections.

The medical records after the injection therapy noted 80% improvement of symptoms as of 02/16, which would be a two-week period, but the patient reported a return of pain in the low back shooting down the left lower extremity toward the foot. After the 04/18/12 injection, the patient was seen 05/22/12 noting good improvement with the February and April injections but failing to document after the last injection specific percentage of improvement or specific length of time the improvement was noted.

The two prior peer reviews, 10/31/12 and 11/16/12, recommended non-certification, as the medical records did not document a response to the prior injections and the medical records did not document physical examination findings correlating with imaging and/or electrodiagnostic study findings for the diagnosis of a radiculopathy, and there was not a response to the concerns from the prior peer reviews.

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

The recommendation is non-certification of the epidural steroid injection by fluoroscopic guidance with epidurography and attendant *CPT* codes 99144, 99145, A-4550, and A-4649, as the medical records do not document physical examination findings with focal neurological deficits that would support a diagnosis of radiculopathy, and the medical records do not contain MRI findings of a lesion that would support the diagnosis of a radiculopathy. The medical records do not document an electrodiagnostic study that would support the diagnosis of a radiculopathy. Therefore, the medical records do not contain information supporting the requested epidural steroid injection with attendant requests in line with *ODG* criteria, and therefore it is not medically necessary.

The prior peer reviewers included physical medicine and rehabilitation, and pain management. The 10/31/12 review recommended non-certification of the LESI noting the *ODG* requirement that a lumbar radiculopathy be documented with objective findings on physical examination and corroborated by imaging studies and/or electrodiagnostic testing, and the indicated that the submitted medical records did not document the response to prior injection therapy and the levels to be injected were not documented. The subsequent 11/16/12 peer review noted recommendation for non-certification of the epidural steroid injection noting lack of clear evidence of a lumbosacral radiculopathy documented on examination notes,

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and there were no imaging studies showing nerve root compression, and there were no EMG studies showing a radiculopathy.

ODG low back chapter on epidural steroid injections that indicate criteria of radiculopathy must be documented with objective findings on examination needing to be present and corroborated by imaging studies and/or electrodiagnostic testing. With such information not present in the medical records provided, the epidural steroid injection is not medically necessary. Therefore, I do agree with the prior peer reviews recommending non-certification of the requested epidural steroid injection.

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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)