

Notice of Independent Review Decision

DATE OF REVIEW: 06/12/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar ESI (no levels submitted) 62311 (76000 J3301 J2250 01992 PNR)

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 ESI (no levels submitted) 62311 (76000 J3301 J2250 01992 PNR) is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 06/03/13
- Notification of Reconsideration Determination from – 05/08/13
- Notification of Adverse Determination from– 03/21/13
- Report of Medical Evaluation – 02/27/13
- Request for Preauthorization – 04/18/13
- Office visit notes – 03/08/13 to 04/12/13

- Office visit notes – 05/29/13 to 04/09/13

PATIENT CLINICAL HISTORY [SUMMARY]:

This injury worker sustained a work related injury on xx/xx/xx when he was driving a motor vehicle and was in the front driver side corner of the care when he was at an intersection and another was hit by a car coming from his left side. He was taken to the emergency department and diagnosed with traumatic myalgia and arthralgia. He was experiencing pain to the neck, mid and lower back and has under gone physical therapy treatment. The patient continues to complain of low back pain that radiates to both lower extremities 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.

In this case, the ODG has not been met. The levels of the epidural steroid injection are not stipulated and the ODG require no more than 2 levels. In addition, radiculopathy should be documented and there is a lack of documentation of radicular distribution of pain. There is a lack of any documentation of radiculopathy. There is also no MRI report that corroborates the level of impingement with the areas of pain.

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 KNOWLEDGBASE
- 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)