



REVIEWER'S REPORT

DATE OF REVIEW: 11/10/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar epidural steroid injection.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Family Practice physician

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

The request for a lumbar epidural steroid injection shows no medical necessity exists with the information given in the records reviewed.

INFORMATION PROVIDED FOR REVIEW:

1. Texas Department of Insurance information including background material and demographic and numerical information
2. Utilization Review records including 10/26/07 letter from to, communication “To Whom It May Concern” by Dr. dated 10/12/07 and another one dated 02/15/07, and other miscellaneous URA review materials
3. The Case Report by M.D. dated 10/04/07
4. The Case Report by Appeal submitted by D.O. dated 10/17/07
5. Preauthorization Request
6. Pain Management dictation notes by Dr.
7. Other “To Whom It May Concern” letters by Dr.
8. Procedure note for a prior epidural steroid injection performed on 02/14/06 on the patient

ODG Guidelines were not presented for review by the carrier.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This is a male who was injured initially. No injury description is provided. The claimant apparently is in constant pain, according to Dr. notes and has difficulty walking with pain radiating down his left leg. He had a previous epidural steroid injection with good results on 02/14/06 and is on medication for his pain including Celebrex, Zoloft, Skelaxin, and Ultram. There is no known or submitted diagnostic testing available, and no surgery has previously been performed. There is no mention of objective findings or differential diagnosis.

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

Although the patient does have left leg pain, this does not prove radiculopathy. There is no notation of objective findings such as loss in sensation, motor function, or deep tendon reflexes. There is no notation of previous imaging findings such as MRI scan nor any plans for future and pre-epidural steroid injection imaging. There is no mention of a differential diagnosis nor a description of a prior injury and neurological findings in previous examinations compared to present examinations on this patient. In summary, although this patient has left leg pain, this does not prove radiculopathy because there are no notations or information about objective findings, nor is there imaging or other testing to help come up with a final diagnosis, possibly allowing approval of an epidural steroid injection. It must be noted that there are other causes of left leg pain including sciatica, which would not respond to an epidural steroid injection. There is also piriformis syndrome as well as other various musculoskeletal and neurological disorders that could cause the symptoms yet not be amenable to an epidural steroid injection. Therefore, with lack of further information and/or imaging, diagnostic studies or anatomic proof of lumbar radiculopathy, the medical necessity for this procedure does not exist.

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

(Check any of the following that were used in the course of your review.)

- 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)