

Clear Resolutions Inc.

An Independent Review Organization

7301 Ranch Rd 620 N, Suite 155-199

Austin, TX 78726

Fax: 512-519-7316

Notice of Independent Review Decision

DATE OF REVIEW: MARCH 23, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Caudal ESI of the lumbar spine with epidurogram followed by post-injection physical medicine for one session only.

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

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

Adverse Determination Letters, 2/8/08, 2/22/08
ODG Guidelines and Treatment Guidelines
IRO Summary, 3/13/08
Employers First Report of Injury or Illness
Associates Statement, 10/27/07
10/29/07
DC, 11/5/07, 12/4/07

MD, 11/8/07, 1/11/08, 1/24/08, 2/7/08, 1/17/08, 1/10/08, 12/20/07, 11/29/07
MRI of Lumbar Spine, 11/19/07, 11/21/07
MD, 12/19/07
MD, 2/12/08
Chiro, 11/5/07
Chiro, 11/6/07, 11/16/07, 11/20/07, 11/27/07, 11/28/07, 11/30/07, 12/4/07, 12/14/07, 12/18/07,
12/19/07, 12/21/07, 1/8/08, 1/15/08, 1/16/08, 1/18/08, 1/22/08, 1/23/08, 1/25/08
Pain Solutions, Daily Progress Note, 1/11/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient started having low back pain when “she tried to lift a file cabinet in the office.” The patient underwent a caudal epidural steroid injection on 01/11/08. The patient was noted to have received 65-70% pain relief for approximately 3-5 days. On 01/24/08, Dr. ordered “caudal epidural steroid injection #2 in order to complete a series of three to get more durable and more permanent pain relief.” In addition, on 02/07/08, Dr. also mentioned that he recommended a second epidural steroid injection “to relieve her pain and radiculopathic symptoms and bring her back to a life free of pain.”

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

Per the *Official Disability Guidelines*, epidural steroid injections should be performed “to reduce pain and inflammation restoring range of motion and thereby facilitating progress in more active treatment programs and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.” Given this description, stating that the procedure would “bring her back to a life free of pain” does not make sense. Therefore, since this is the intention of the epidural steroid injection, a second injection would not be indicated at this time. In addition, a “series of three” epidural steroid injections is not recommended per the *Official Disability Guidelines*. Also, there is some question as to how much the patient benefited from the initial epidural steroid injection. Per an office visit note dated 02/12/08, Dr. stated that after having the one epidural steroid injection the patient had “a problem with increased back pain.” Given all of this information, the reviewer finds that a Caudal ESI of the lumbar spine with epidurogram followed by post-injection physical medicine for one session only is not medically necessary.

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)**