

Notice of Independent Review Decision

DATE OF REVIEW: 10/13/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Caudal epidural steroid injection with fluoroscopy localization

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

The TMF physician reviewer is a board certified orthopedic surgeon 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 caudal epidural steroid injection with fluoroscopy localization is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Notice of case assignment – 10/02/08
- Information for review by an IRO – 10/01/08
- Letter of determination from – 09/11/08, 09/12/08, 09/26/08
- Report of independent medical evaluation by Dr. – 05/20/08

- Chart notes by Dr – 06/09/08 to 08/29/08
- Report of Piriformis steroid block – 08/04/08
- Report of selective nerve root blocks – 06/30/08
- Report of lumbar myelogram – 09/13/05

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was unloading a pallet of flour and he slipped and fell. This resulted in injury to his lower back. He complains of left lower extremity pain in excess of lumbar pain. He has been treated with 3 surgical procedures; 05/23/04, laminectomy, discectomy, foraminectomy left L5-S1, 04/27/06, 2 level posterior lumbar interbody fusion at L4-S1, 06/05/07, coccygectomy. Additionally, he has been treated with medication, NSAIDs, pain medications, muscle relaxant medications, chiropractic manipulations and physical therapy.

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

The patient suffers from failed back syndrome, chronic lumbar pain and chronic neuropathy. The ODG, 2008, Pain chapter, epidural steroid injections, provides criteria for the performance of epidural steroid injections. It does not appear that this patient's clinical circumstances and findings meet these criteria. The patient underwent epidural steroid injections in 2007 with results lasting only days. The medical records do not include information that would allow the previous requests to be overturned. The lumbar myelogram was performed in 2005 and MRI scans were performed in 2004. A suggestion that L5 and L1 nerve root tethering has been offered without any significant documentation to support the diagnosis.

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)