



Notice of Independent Review Decision

DATE OF REVIEW: 12/17/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Caudal epidural steroid injection

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in private practice of Pain Management full time since 1993

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Medical necessity has not been demonstrated for the requested caudal epidural steroid injection.

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
724.2	62311		Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:

- TDI case assignment.
- Letters of denial 11/03 & 10/19/09, including criteria used in the denial.
- Treating doctors OV 02/27/09 – 10/13/09 (4 visits).
- Orthopedic consultation 10/26/09.
- MRI – lumbar spine w/o contrast 05/11/09.
- Pain management initial H&P 12/12/08.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This individual sustained a lifting injury in xx/xxxx. After failure of conservative care, he had a fusion in July 2009, which helped the numbness in his leg, but he has persistent back and hip pain. Imaging studies show that the fusion is stable. MRI scan shows diffuse bulges with no nerve impingement. Previous injections have not been helpful. He has undergone a recent course of physical therapy, but the pain persists.

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

<p>P. O. Box 215 Round Rock, TX 78680 (1908 Spring Hollow Path, 78681) Phone: 512.218.1114 Fax: 512.287-4024</p>	
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The ODG Guidelines stipulate that there should be objective evidence of radiculopathy. This individual does not have pain in a radicular fashion, has no nerve impingement on MRI scan, and has no motor deficit, and no electrodiagnostic evidence of radiculopathy. The ODG criteria are not met.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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.)

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