US Resolutions Inc.

An Independent Review Organization
71 Court Street
Belfast, Maine 04915

Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 15, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar epidural block L5-S1 under fluoroscopy

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

M.D., Board Certified Orthopedic Surgeon.

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.

The reviewer finds that medical necessity does not exist for Lumbar epidural block L5-S1 under fluoroscopy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 11/28/08, 12/18/08
ODG Guidelines and Treatment Guidelines
MRI lumbar spine, 10/11/06
Office notes, Dr., 10/18/06, 01/11/08, 02/22/08, 03/28/08, 11/12/08
ESI, 2/01/06, 08/13/07, 02/21/08, 04/15/08
Job Specification, undated
Fax Request/Pre Auth Request, 11/18/08, 12/09/08
Prescription, 10/18/06, 07/27/07, 01/11/08, 11/12/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old male injured on xx/xx/xx. The most recent diagnosis was noted to be lumbar degenerative disc disease. A 10/11/06 MRI of the lumbar spine showed degenerative disc disease at L1-2, L3-4 and L5-S1 and bulging at L1-2 and L3-4. At L5-S1 was a left central and subarticular herniation/protrusion with slight deformity of the left S1 nerve root. On 10/18/06 Dr. saw the claimant for low back pain. Dr. noted the claimant had evidence of S1 radiculopathy although no examination was documented. Epidural steroid injection (ESI) was recommended. The claimant had injections on 2/01/06 and 08/13/07 at L5-S1. The claimant returned to Dr. on 03/28/08 with reported increased pain and stiffness. On examination the neurological examination was noted to be intact. The claimant was given Zanaflex and had another steroid injection on 04/15/08.

On 11/12/08 Dr. saw the claimant for chronic back pain and electric shock sensation in the lower extremities. On examination straight leg raise caused right leg pain with sciatic-like symptoms. The neurological status remained intact. The diagnosis was degenerative disc disease and another injection was requested.

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

After review of the clinical records there is no objective evidence that the claimant has radiculopathy on examinations. There is no description of pain in a radicular fashion. There is no clear neurocompressive pathology on the 2006 MRI. The physician has documented that this claimant's neurological status is intact. The records do not contain electrodiagnostic studies to confirm a radiculopathy. Based on the lack of findings as noted, the claimant does not appear to meet ODG criterion for epidural steroid injection. The reviewer finds that medical necessity does not exist for lumbar epidural block L5-S1 under fluoroscopy.

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)**