

SENT VIA EMAIL OR FAX ON
May/11/2009

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 594-8608
Email: rm@truedecisions.com

DATE OF REVIEW:

May/11/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Epidural Steroid Injection, L5/S1 Under Fluoroscopic Guidance

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

OD Guidelines

Denial Letters 4/7/09 and 4/20/09

Dr 3/19/09, 3/31/09

Radiology Reports 3/24/09 and 3/12/09

Center 3/19/09

Consult 3/16/09 Dr.

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a date of injury xx-xx-xx, when he was involved in a motor vehicle accident. He complains of persistent neck pain with radiation into the right upper extremity. He also complains of upper thoracic pain. He has taken narcotics and muscle relaxants for the pain. His neurological examination reveals weakness in the right deltoid and triceps. An MRI of the lumbar spine 03/24/2009 reveals bilateral facet arthropathy causing minimal impression upon the posterior thecal sac without central stenosis. There is mild left foraminal narrowing. The provider is requesting an L5-S1 epidural steroid injection under fluoroscopic guidance.

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

The L5-S1 ESI is not medically necessary. Firstly, only cervical and upper thoracic complaints have been documented. Secondly, the ODG recommends ESI's if there is a failure of conservative therapy to alleviate symptoms. There is no documentation of conservative therapy, including PT. Lastly, the ODG necessitates objective evidence of radiculopathy. There is no objective evidence of radiculopathy from the L5-S1 level, nor is

there any significant amount of nerve root compression noted on the lumbar MRI at this level. His condition does not fulfill these criteria; therefore, the L5-S1 ESI is not medically necessary.

References/Guidelines

Occupational and Disability Guidelines, "Low Back" chapt

Criteria for the use of Epidural steroid injections:

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

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)