

Notice of Independent Review Decision

DATE OF REVIEW: 10/5/2009
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Epidural Steroid Injection

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from Texas College of Osteopathic Medicine and completed training in Physical Med & Rehab at The University of Texas Health Science Center. This reviewer is also boarded in Pain Management. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 7/1/2006 and currently resides in TX.

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)

Epidural Steroid Injection Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Notice of assignment dated 09/14/2009
2. Follow up note by DO dated 07/21/2009
3. Peer to peer by DO dated 06/10/2009
4. Radiology report by DO dated 06/10/2009
5. Follow up note by DO dated 06/10/2009
6. Radiology report by DO dated 04/20/2009
7. Follow up note by DO dated 04/20/2009
8. Clinical note dated 09/14/2009
9. IRO request form by author unknown dated 09/14/2009
10. Review of case assignment dated 09/14/2009
11. Request form dated 09/12/2009
12. Reconsideration by author unknown dated 09/02/2009
13. Utilization review by author unknown dated 08/14/2009
14. Official Disability Guidelines (ODG)

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a male who presents with suspected postoperative radiculitis causing radicular leg pain. Provider recommended epidural steroid injections. The injured employee was recommended for caudal epidural steroid injection. The injured employee is noted as having a prior CT scan of the lumbar spine on 07/15/09 noting posterior fusion at L4-S1 with transpedicular screws and plates. There was evidence of a 3 mm right paracentral disc protrusion at L1-2 and minimal retrolisthesis at L3 on 4. Physical examination noted 5/5 strength, intact sensory, and negative straight-leg raise. Radiographs noted good placement of the lumbar hardware and prior examination on 06/10/09 noted continued negative findings and no evidence of progressive neurologic deficit.

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

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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)