Advanced Medical Reviews

URAC ACCREDITED EXTERNAL REVIEW

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 7/22/2010
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Caudal epidural steroid injection

QUALIFICATIONS OF THE REVIEWER:
Occupational Medicine

REVIEW OUTCOME:
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

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

Caudal epidural steroid injection Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Review of case assignment by dated 07/02/2010
2. Request form by author unknown, dated 06/28/2010
3. Letter by MD dated 06/23/2010
4. Notification of determination by DO dated 05/19/2010
5. IRO form by author unknown, dated unknown.

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a male whose industrial injury is listed as xx/xx/xx. He attempted to hold up a falling heavy freight when he sprained his thoracic and lumbar spine. This industrial accident also led to his right sciatic nerve impingement. He has been treating with Dr., Occupational and Pain Medicine, who last examined him on 5/29/10. On that day he was complaining of sharp, burning, shooting pain radiating to his right lower extremity (RLE) which was also associated with numbness. On physical exam (PE), his vital signs were stable. There was tenderness on the midline at L3-S1. Lumbar flexion/extension was within normal limits (WNL) with pain at end range. Dermatomes, myotomes, and reflexive zones were WNL except for L5 dermatome on the right. Straight leg raise (SLR) test in sitting position was positive on the right. His muscle testing was 5/5 throughout. Deep tendon reflexes (DTR) were 2+/4 bilaterally. He was diagnosed with Nerve Root Compression (Lumbar), and Lumbago. The following is an all inclusive list of all his medications since Jan. 2010: Neurontin, Naprelan, Robaxin, and Lortab. On that day his meds were renewed and there was a repeat request for caudal epidural steroid injection (ESI). A review of the submitted clinical shows that this claimant was seen by the same provider on 5/18/10, 4/15/10, and 1/28/10. His clinical presentation, subjective complaints, objective physical exam findings, diagnosis, treatment recommendations, and prognosis remained essentially the same throughout.

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

This injured employee was status post lumbar surgery since 11/96 when he reinjured his lower back on x/xx/xx. He now has subjective pain to the lower back with radiation to his left lower extremity (LLE) for which he is under adequate pharmaceutical coverage. On his most recent PE dated 5/29/10 he had normal gait, and no motor deficits. His DTR remained 2+/4. There were no signs of muscle atrophy. The submitted clinical do not include any advanced diagnostic testing positive results documenting objective findings which could result in radiculopathy. There is no documentation of previous trials of ESIs with their outcome. There is no mention of Home Exercise Program which is necessitated by the ODG guidelines as an adjunct to ESIs to improve and prolong a positive outcome. With the limited information contained in the submitted clinicals, the above request is not reasonable or medically necessary. The recommendation is to uphold the previous denial.

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
X 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)