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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jun/01/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar epidural steroid injection

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

M.D., board certified in Orthopedic Surgery

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

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 4/8/10, 4/20/10
M.D. 4/7/10
M.D. 3/30/10, 1/29/10, 12/17/09, 10/12/09, 3/23/10
Health & Medical 3/31/10
BDI 5/7/09, 4/13/09
Memorial MRI, 12/4/09
PUBMED article, 10 pages

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who is stated to have left-sided neural foraminal stenosis with neurogenic claudication. There is no documentation of radiculopathy or current clinical complaints of radiculopathy noted within the medical records provided. The patient has had medication management and physical therapy. Current diagnosis is of neurogenic claudication. Current request is for an epidural steroid injection.

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

Given the absence of radiculopathy within the medical records, the Official Disability Guidelines and Treatment Guidelines are not satisfied. It is noted that radiculopathy must be documented. Objective findings on examination need to be present or unequivocal evidence

of radiculopathy according to the AMA Guidelines with attention to page 382-383. This patient's medical records do not demonstrate findings compatible with objective findings of radiculopathy. It is for this reason the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for Lumbar epidural steroid injection.

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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