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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/24/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Caudal Epidural Steroid Injection

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

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

Corporation, 4/22/10, 4/7/10

DO, 4/28/10, 4/12/10, 3/25/10

Imaging 3/4/09

ODG-TWC

10/8/09

PATIENT CLINICAL HISTORY SUMMARY

The patient has a history of "chronic, severe, low back, left lumbar, left leg pain associated with numbness, weakness, occasional bowel or bladder dysfunction, following a work related injury." Patient has a "positive straight leg raise sign" bilaterally. Per the note, the patient was neurologically intact. There is no mention of the patient being involved in an active treatment program during the performance of the requested ESI. The patient received a lumbar ESI on 8/20/09 which provided 1 week of "good relief" and a second lumbar ESI on 11/23/09 which also provided good relief for 1 week. The last MRI was performed on 3/4/09. It was significant for "severe bilateral L5 neural foraminal narrowing related to a L5 retrolisthesis combined with broad posterior and posterolateral disc bulging."

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

Per the Official Disability Guidelines, a therapeutic ESI is not considered appropriate if the diagnostic ESI's were not "found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks." This is not the case. In addition, there is no mention in the records of involving the patient in an active treatment program. It is noted in the ODG that "The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit." The reviewer finds that medical necessity does not exist at this time for Lumbar Caudal 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)