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Notice of Independent Review Decision

DATE OF REVIEW: 10/22/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient lumbar epidural steroid injection (ESI) at L4-L5 and L5-S1

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

Board Certified in Orthopedic Surgery

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Outpatient lumbar epidural steroid injection (ESI) at L4-L5 and L5-S1 – Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 04/09/10, 05/07/10, 06/03/10, and 07/21/10

Letters written "To Whom It May Concern" from M.D. dated 08/25/10 and 09/04/10
An evaluation with Dr. dated 08/25/10
A letter of non-authorization, according to the Official Disability Guidelines (ODG), from D.O. dated 08/31/10
A letter of non-authorization, according to the ODG, from M.D. dated 09/13/10
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 04/09/10 and 05/07/10, Dr. performed a Toradol injection and prescribed a Medrol Dosepak, Tramadol, and Etodolac. On 06/03/10, Dr. provided Hydrocodone/APAP and a referral to Dr.. On 08/25/10, Dr. recommended an epidural steroid injection (ESI), continued physical therapy, a TENS unit, and an LSO brace. On 08/31/10, Dr. wrote a letter of non-authorization for a lumbar ESI at L4-L5 and L5-S1. On 09/04/10, Dr. wrote a letter of medical necessity for the ESI. On 09/13/10, Dr. wrote a letter of non-authorization for the lumbar ESI.

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

The patient does not meet the Official Disability Guidelines (ODG) criteria for ESIs. In the pain diagram the patient filled out in the initial pain assessment, his pain does not go below the knee, one of the requirements for radiculopathy. Further, there is no evidence of neurological dysfunction or sensory change that would lead to the diagnosis of radiculopathy. The patient had axial lower back pain. There is no indication for an ESI in the treatment of this patient's residual pain. Therefore, the requested outpatient lumbar ESI at L4-L5 and L5-S1 is neither reasonable nor necessary according to the ODG and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE**
- ☐ **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
- [x] 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)