Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 10/06/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Epidural Steroid Injection (ESI) # 2

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

Board Certified in Physical Medicine & Rehabilitation

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)

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.

Lumbar Epidural Steroid Injection (ESI) # 2 – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- History and Physical, M.D., 04/30/10
- Progress Note, 06/09/10, 08/25/10
- Initial Office Note, M.D., 06/29/10
- X-ray Lumbar Spine, Dr. 06/29/10
- Electrodiagnostic Study Report, Dr. 07/12/10
- Follow up and Procedure Note, Dr. 08/03/10
- Progress Note, Dr. 08/18/10
- Follow up Note, Dr. 08/19/10
- Denial Letter, 08/25/10, 09/08/10
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The date of injury was listed as xx/xx/xx. The records available for review document that the patient developed a difficulty with symptoms of low back pain and left lower extremity pain when he was lifting and pulling.

The patient was evaluated by Dr. on 04/30/10. On that date, it was documented that a lumbar MRI had been accomplished, which revealed findings consistent with a "bulging disc at L4-L5 and a herniated disc and L3-L4 and L5-S1. The patient was provided a prescription for Amrix, Celebrex, and Ultracet. It was recommended that he receive access to treatment in the form of physical therapy.

He was then evaluated at on 06/08/10. On that date, it was recommended that an electrodiagnostic assessment of the left lower extremity be accomplished.

The patient was evaluated by Dr. on 06/29/10. This physician indicated that lumbar spine x-rays were available for review which revealed findings consistent with a mild compression fracture at the L1 vertebra with mild spondylitic changes at the L4-L5 and the L5-S1 levels. It was recommended that an electrodiagnostic assessment of the left lower extremity be accomplished.

An electrodiagnostic assessment of the left lower extremity was obtained on 07/12/10. This study revealed findings consistent with a left L5-S1 radiculopathy.

Dr. re-evaluated the patient on 08/03/10. On this date, the patient received a lumbar epidural steroid injection.

The patient was evaluated by Dr. on 08/18/10. It was noted that he was with symptoms of low back pain and with radiation to the left lower extremity. Treatment in the form of a lumbar epidural injection and physical therapy did not help to decrease pain symptoms.

Dr. evaluated the patient again on 09/19/10. A previous attempt at a lumbar epidural steroid injection provided a slight reduction in pain symptoms. It was recommended that the patient receive a second lumbar epidural steroid injection.

The claimant was evaluated at the on 08/25/10. It was recommended that consideration be given for a neurosurgical consultation.

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

Based upon the medical records available for review, the Official Disability Guidelines would not support the medical necessity for a repeat lumbar epidural steroid injection. The records available for review document that there was no significant reduction in pain symptoms with a previous attempt at a lumbar epidural steroid injection. As a result, the Official Disability Guidelines would not support an attempt at a repeat lumbar epidural steroid injection. Given the fact that there was not a significantly positive response to a previous attempt at a lumbar epidural steroid injection, the Official Disability Guidelines would not support a medical necessity for a repeat lumbar epidural steroid injection. Consequently, per the criteria set forth by the above noted reference, a repeat lumbar epidural steroid injection would not be considered a medical necessity.

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)**
- ☐ **AMA GUIDES 5TH EDITION**