

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/20/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

One Lumbar Epidural Steroid Injection L4-L5 Under Fluoroscopy

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

M.D., Board Certified in Anesthesiology

Board Certified in Pain Management

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 Treatment Guidelines

Health Direct, Inc., 8/10/10, 8/31/10

Pain Institute 7/27/10, 5/12/09, 5/29/08, 6/6/08, 2/7/08

PATIENT CLINICAL HISTORY SUMMARY

This patient is a male with a date of injury on xx/xx/xx. Records from 2008-2010 were available for review. At a follow-up office visit with Dr. on 7/27/10, it is noted that this patient is complaining of "pain to the lower back and left lower extremity." A dermatomal pattern of the pain is not described. He has a SCS. Superficially, it is noted that the patient has radicular symptoms. The physical exam does not show any signs of radiculopathy in any of the office visits that were reviewed from 2008-2010.

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

Per the ODG, for a lumbar ESI to be considered appropriate, "radiculopathy must be documented. Objective findings on examination need to be present." Superficially, it is noted that the patient has radicular symptoms. However, these symptoms are not described sufficiently in the records to tell if they are truly radicular. In addition, there are no objective findings noted on exam. Based on this information, a lumbar ESI is not considered appropriate at this time. The reviewer finds that medical necessity does not exist for One Lumbar Epidural Steroid Injection L4-L5 Under Fluoroscopy.

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)