

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/15/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Caudal lumbar ESI with Catheter

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

MD, Board Certified in Anesthesiology

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 Low Back, ESI

Adverse determination notice 03/08/11

Adverse determination after reconsideration notice 03/18/11

Response to request for IRO 03/31/11

Peer review M.D. 12/28/09

Initial pain evaluation follow-up notes M.D. 02/11/08-02/28/11

Operative report caudal epidural steroid injection, lysis of epidural adhesions, trigger point injections 01/05/11

Lumbar spine MRI 08/31/07

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a XX year-old male whose date of injury is XX/XX/XX. Records indicate the injured employee fell 10 feet from a ladder. He is status post 360 lumbar fusion performed 11/26/08 at L4-5 and L5-S1. Records indicate the injured employee has failed spinal cord stimulator. On 01/05/11 the injured employee underwent caudal epidural steroid injection using lysis of adhesions technique. Progress note on 01/06/11 reported greater than 70% improvement, and repeat injection was recommended.

A request for caudal lumbar epidural steroid injection was reviewed by Dr. on 03/08/11. Dr. determined the request was non-certified as medically necessary. It was noted the injured employee had at least one epidural steroid injection (on 09/01/09). There was improvement, but pain was still rated 10/10. Reflexes, lower extremity strength, muscle asymmetry, sensory testing, and straight leg raise test with anatomical localization of signs and symptoms are the minimum required when radiculopathy is diagnosis. Dr. noted it was unclear what levels epidural steroid injections would be performed, and was unclear if they were to be right, left or bilateral. Dr. concluded there was insufficient information upon which to determine cogent determination of medical necessity.

A reconsideration / appeal request for caudal epidural steroid injection was reviewed by Dr. on 03/18/11. Dr. determined the request to be non-certified. It was noted the claimant has history of low back pain and diagnosis of postlaminectomy syndrome. Low back pain radiates into lower extremities. Dr. noted there was no physical examination documented. The claimant had epidural steroid injection on 01/05/11 which gave the claimant relief, but there was no documentation as to percent of pain relief and how long they achieved relief / duration. Dr. concluded that repeat epidural steroid injection is non-certified.

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

The reviewer finds no medical necessity for Caudal lumbar ESI with Catheter. The patient is noted to have sustained an injury to low back when he fell from ladder. The claimant underwent two level 360 degree fusion on 11/26/08. The patient continued to complain of low back pain radiating to lower extremities. A caudal lumbar epidural steroid injection was performed on 01/05/11. Progress note dated 01/06/11 indicated greater than 70% improvement following epidural steroid injection. However, there was no indication of duration of relief. Per ODG guidelines, there should be at least 50-70% pain relief lasting at least 6-8 weeks to support repeat injections. It is also noted that no current imaging studies were submitted for review with objective evidence of neurocompressive pathology in lumbar spine. There was no detailed physical examination with evidence of motor, sensory or reflex changes, or other indications of radicular symptoms. ODG guidelines indicate that radiculopathy must be documented with objective findings on examination present, and radiculopathy corroborated by imaging studies and / or electrodiagnostic testing. Given the current clinical data, medical necessity is not established for Caudal lumbar ESI with Catheter.

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)