SENT VIA EMAIL OR FAX ON
Nov/30/2011

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

Amended 11/30/11
Date of Notice of Decision: Nov/28/2011

DATE OF REVIEW:
Nov/22/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Caudal ESI

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Cover sheet and working documents
Utilization review determination dated 10/21/11, 11/14/11
Peer review dated 09/21/11
Injection scheduling form dated 09/20/11
Office visit note dated 09/20/11, 08/18/11, 08/02/11
MRI lumbar spine dated 08/12/11
Operative report dated 08/31/11

PATIENT CLINICAL HISTORY SUMMARY
The patient is a female whose date of injury is xx/xx/xx. On this date the patient fell .

Treatment to date is reported to include physical therapy and TENS unit. MRI of the lumbar spine dated 08/12/11 revealed multilevel lumbar spine degenerative changes with L5-S1 right paracentral focal disc protrusion resulting in right lateral recess narrowing with impingement of traversing right S1 nerve root. The patient underwent caudal epidural steroid injection on 08/31/11. Follow up note dated 09/20/11 indicates that pre-injection pain level was 9/10 and post injection pain level is 6/10. The injection "worked great for about 2 weeks". Physical examination on 09/20/11 notes full pain free range of motion of the bilateral lower extremities. There is a diminished right Achilles reflex. Sensation is intact and symmetric in the bilateral lower extremities. Lower extremity strength is rated as 5/5 throughout. Peer review report dated 09/21/11 notes that lumbar epidural steroid injection is not medically necessary as the patient had 60% improvement for two weeks with the first epidural steroid injection.

Initial request for caudal epidural steroid injection was non-certified on 10/21/11 noting that the patient reported 60% pain relief after the first epidural steroid injection, but only for two weeks. Per Official Disability Guidelines, if after the initial block/blocks are given and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. The denial was upheld on appeal dated 11/14/11 noting that the patient did not sustain adequate relief after the initial caudal epidural steroid injection.

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

Based on the clinical information provided, the request for caudal epidural steroid injection is not recommended as medically necessary, and the two previous denials are upheld. The patient's physical examination does not establish the presence of active lumbar radiculopathy. The patient underwent previous caudal epidural steroid injection on 08/31/11. Per follow up note dated 09/20/11, the patient reported 60% pain relief for only two weeks. The Official Disability Guidelines support repeat epidural steroid injection with evidence of at least 50-70% pain relief for at least 6-8 weeks. Given the current clinical data, the requested caudal epidural steroid injection is not indicated as medically necessary.

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

[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)