

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 02/18/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar epidural steroid injection number two, L4/L5, with IV sedation and fluoroscopy (62311 PNR 77003)

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering lumbar pain problems

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
722.1	62311		Prospective						Upheld

INFORMATION PROVIDED FOR REVIEW:

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a xx-year-old female who suffered a straining injury to her lumbar spines while lifting. She suffers low back pain, and bilateral lower extremity pain is reported. Weakness in the right lower extremity is reported though not definitively defined. She has no deep tendon reflexes abnormalities. An MRI scan dated 08/04/10 revealed herniated nucleus pulposus at the level of L4/L5 on the right side with a free fragment and on the left side at L5/S1. The patient

underwent caudal epidural steroid injections on 11/15/10. The result of that injection has been limited. The patient apparently received an estimated 10% benefit in pain relief. The current request is for a second lumbar epidural steroid injection. This request has been considered and denied, reconsidered and denied.

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

It is not clear that this patient suffers clear radiculopathy. An electrodiagnostic study performed on 07/08/10 was normal. The first lumbar epidural steroid injection provided only limited benefit with estimation of 10% reduction in pain. The second lumbosacral epidural steroid injection does not appear to be indicated. Criteria published in the ODG 2011 Low Back Chapter have not been met.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)