

I-Resolutions Inc.

An Independent Review Organization
8836 Colberg Dr.
Austin, TX 78749
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/07/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Second Lumbar ESI at L3-S1

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

MD, Board Certified Anesthesiologist
The American Board of 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

Official Disability Guidelines, Criteria for the use of ESI

04/14/11, 05/04/11

Office visit notes, 03/31/11, 04/07/11, 09/14/10, 07/15/10, 10/21/10

Daily note dated 09/17/10, 08/24/10, 08/31/10, 07/27/10, 08/03/10, 07/06/10, 07/13/10, 06/22/10, 06/29/10, 06/10/10, 06/15/10, 06/03/10, 06/08/10, 05/27/10, 06/01/10, 05/21/10, 05/25/10, 05/13/10, 05/18/10, 05/07/10, 05/11/10, 04/30/10, 05/04/10, 04/20/10, 04/27/10, 04/14/10, 04/16/10, 04/06/10, 04/09/10, 03/30/10, 03/31/10, 03/24/10, 03/25/10, 03/16/10, 03/18/10, 03/04/10, 03/12/10, 01/21/10, 01/28/10, 01/12/10, 01/18/10

Shoulder evaluation/care plan, 03/02/10, 01/12/10

Letter, 04/29/11

MRI lumbar spine, 08/31/09

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. MRI of the lumbar spine dated 08/31/09 revealed 2 mm diffuse annular disc bulge at L4-5 asymmetrically more prominent toward the left abutting the left L5 nerve root within the left L4-5 lateral recess without central stenosis or neural foraminal narrowing; mild disc space desiccation at L4-5 and L5-S1; mild bilateral facet joint hypertrophy at L4-5 and L5-S1. Pain clinic note dated 03/31/11 indicates that the patient underwent lumbar epidural steroid injection #1 the prior month and states it worked very well for 4 days and then symptoms gradually returned. The patient is status post left rotator cuff repair. On physical examination there is tenderness to palpation to the lumbar facets on the right side. Straight leg raising is positive on the right.

Initial request for second lumbar epidural steroid injection at L3-S1 was non-certified on 04/14/11 noting the clinical information did not provide objective documentation of the

patient's clinical and functional response from the previous epidural steroid injection that includes sustained pain relief of at least 50-70% for at least 6-8 weeks, increased performance in ADSs and reduction in medication use. The denial was upheld on appeal dated 05/04/11 noting there is no documentation provided with regard to the failure of the patient to respond to conservative measures. The patient's response to previous epidural steroid injection is not documented.

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

Based on the information provided, the reviewer finds there is not a medical necessity at this time for Second Lumbar ESI at L3-S1. The submitted records indicate that the patient underwent an initial epidural steroid injection in February 2011. The follow up note dated 03/31/11 indicates that the patient reported that the injection worked very well for 4 days and then symptoms gradually returned. The Official Disability Guidelines support repeat epidural steroid injection only with evidence of at least 50-70% pain relief for at least 6-8 weeks. Additionally, the request does not meet current guidelines, as ODG recommends that no more than two nerve root levels should be injected. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

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)