SENT VIA EMAIL OR FAX ON
Mar/12/2011

Applied Assessments LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Mar/08/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar ESI Caudal

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

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
1. Cover sheet and working documents
2. Utilization review determination dated 01/25/11, 02/16/11
3. Follow up note dated 02/09/11
4. MRI lumbar spine dated 12/31/10
5. Radiology report dated 02/08/11
6. Consultation dated 01/13/11
7. Radiographic report dated 01/13/11
8. Office visit note dated 12/14/10, 12/15/10, 01/04/11

PATIENT CLINICAL HISTORY SUMMARY
The patient is a male whose date of injury is XX/XX/XX. On this date the patient was pulling a load and injured his lower back. Physical therapy initial evaluation dated 12/14/10 reports diagnosis is lumbar strain. On physical examination lumbar range of motion is flexion 70, extension 5. MMT is rated as 5/5 throughout the bilateral lower extremities. Straight leg raising is within normal limits. Deep tendon reflexes are 2+ throughout the lower extremities.

MRI of the lumbar spine dated 12/31/10 revealed moderate discogenic and facet degenerative arthrosis; disc extrusion at T12-L1 and protrusions between L3 and L5; mild thecal sac narrowing at T12-L1 and L4-5 from disc herniations; moderate thecal sac narrowing at L4 and L5 from thick epidural fat; neural foraminal narrowing appears significant on the left between L3 and L5 and on the right at L4-5.

Progress note dated 01/04/11 indicates that the patient has completed 2 sessions of physical therapy and reports that his pattern of symptoms is no better. The patient reports that pain radiates to both legs. Consultation dated 01/13/11 indicates that on physical examination gait pattern is normal. Motor strength is rated as 5/5 in the upper and lower extremities. Sensation is grossly intact throughout. Overall, he is neurologically intact. The patient is working light duty. The patient was started on steroid pack, Celebrex, Ultracet and Zanaflex.

Initial request for lumbar epidural steroid injection caudal was non-certified on 01/25/11 noting that the patient's physical examination notes that he is neurologically intact without evidence of clinical radiculopathy. The denial was upheld on appeal dated 02/16/11 noting that submitted records do not document an objective neurologic deficit.

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 lumbar epidural steroid injection caudal 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 with intact sensation, 5/5 strength and 2+ deep tendon reflexes throughout the bilateral lower extremities. Current evidence based guidelines support an epidural steroid injection only for patients with documented radiculopathy who have been unresponsive to conservative treatment. The submitted records indicate that the patient has undergone only 2 sessions of physical therapy. Given the current clinical data, the requested lumbar epidural steroid injection caudal is not indicated as medically necessary, and the two previous denials are 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

[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)