



Notice of Independent Review Decision

DATE OF REVIEW: 5/09/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

LUMBAR EPIDURAL STEROID INJECTION # 2

INJECTION, SINGLE (NOT VIA INDWELLING CATHETER), NOT INCLUDING NEUROLYTIC SUBSTANCES, WITH OR WITHOUT CONTRAST (FOR EITHER LOCALIZATION OR EPIDUROGRAPHY), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S)

CPT 62311, 36000, 72100, 76000, 00630

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

D.O. whose specialty is Anesthesiology and Pain Management

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

Document Type	Date(s) - Month/Day/Year
Notice of Case Assignment	4/20/2011



Notice of Adverse Determination	3/30/2011
Notification of Reconsideration (appeal) Decision	4/15/2011
Appeal Decision Form	4/19/2011
Peer Review Reports	3/28/2011, 4/15/2011
Reconsideration Request	
Office visits Notes	2/11/2011-3/24/2011
History and Physical Examination	1/04/2011
Radiology Report	12/24/2010
Physical Therapy Evaluation	12/23/2010-1/10/2011
Status Report Follow-up Evaluation	
Work Status Report	12/17/2010
Decision	3/07/2011

PATIENT CLINICAL HISTORY [SUMMARY]:

Claimant is a XX year old male who was injured XX/XX/XX. The claimant was on top of a truck trying to open a lid when he felt a pop in his back. Patient had an MRI of the lumbar spine, medication, physical therapy and one epidural steroid injection. The lumbar MRI dated 12/24/2010 with impression: Evidence of disc disease mainly affecting the end plates with the mild diffuse disc herniation present at the levels of L2-3 and moderate herniation to the left at L3-4. Patient treated with Physical Therapy and medication with limited success. Patient was seen by Orthopedic Surgeon (Dr. 1/4/11). Patient deemed not a surgical candidate, subsequently, patient had an epidural steroid injection after which the office visit note dated 3/3/11 by Dr. indicates that the patient reported 50% relief x 2 weeks. In the follow-up note by Dr. on 3/24/11, the patient reported that the lumbar epidural steroid injection made his pain worse, and on physical exam, patient had decreased tendon reflexes in the lower extremities bilaterally and positive leg raise test bilaterally.

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

Lumbar epidural steroid injection #2 is not warranted.

The ODG Guidelines chapter on low back pain is as follows:

“Therapeutic phase: If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported.”



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According to the notes from Dr. on 3/3/11, the patient had 50% relief for two weeks. When the pain came back, according to the notes from Dr. on 3/24/11, patient reported that he was worse after the epidural steroid injection. Since the patient has conflicting reports, on the extent of relief from the epidural steroid injection, and since he had only two weeks of relief according to the note from 3/3/11, the patient is not a good candidate for repeat epidural steroid injection according the ODG Guidelines chapter on low back pain as the patient did not have pain relief for at least 6-8 weeks.

References:

The ODG Guidelines chapter on Low back pain

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE
- 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)