

SENT VIA EMAIL OR FAX ON
Jan/10/2012

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/10/2012

IRO CASE #:

38820

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient epidural steroid injection (ESI) number two (2) caudal under fluoroscopy as related to the lumbar spine

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

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

OD Guidelines

Cover sheet and working documents

Utilization review determination dated 11/02/11, 11/30/11

Follow up note dated 10/20/11, 08/15/11, 11/10/11, 09/15/11, 12/05/11, 09/02/11

Lumbar myelogram dated 04/29/09

MRI lumbar spine dated 08/30/07

Operative report dated 10/12/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. On this date the patient moved 100 lb test board and noted low back pain. MRI of the lumbar spine dated 08/30/07 revealed postoperative changes with bilateral laminectomies and surgical fusion of L4 on L5 with enhancing fibrosis surrounding the thecal sac as well as along the posterior paraspinous soft

tissues; no focal recurrent disc protrusion demonstrated. Initial pain evaluation dated 08/15/11 indicates that the patient has been treated with multiple surgical interventions. The patient underwent caudal epidural steroid injection on 10/12/11. Follow up note dated 10/20/11 indicates that the patient reports at least 70% individual psychotherapy following the epidural steroid injection. Follow up note dated 11/10/11 indicates that the patient reports her left buttock and left leg pain have completely resolved.

Initial request for caudal epidural steroid injection #2 was non-certified on 11/02/11 noting that the previous epidural steroid injection was approved very recently, and the patient reported 70% improvement, but just now for 10 days. The denial was upheld on appeal dated 11/30/11 noting that in a therapeutic phase, 70% pain relief meets one of the criteria for a repeat procedure, but there is no radicular pain. ODG are not met for the caudal ESI #2 since only axial back pain remains.

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 outpatient epidural steroid injection number two caudal under fluoroscopy as related to the lumbar spine is not recommended as medically necessary, and the two previous denials are upheld. There is no current, detailed physical examination submitted for review to establish the presence of active lumbar radiculopathy, and there are no recent imaging studies/electrodiagnostic results provided to support the diagnosis as required by the Official Disability Guidelines. The patient underwent initial epidural steroid injection on 10/12/11. ODG supports repeat epidural steroid injection with evidence of at least 50-70% pain relief for at least 6-8 weeks. The submitted records fail to establish that the patient's pain relief satisfies these criteria.

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)