

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/12/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral Transforaminal Lumbar ESI L4-S1 and L5-S1 under Anesthesia (#2)

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

M.D., Board Certified Pain Medicine

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
Utilization review determination dated 01/23/12, 01/31/12
Office visit note dated 02/17/12, 01/13/12, 12/16/11, 11/21/11, 10/24/11, 09/28/11, 08/31/11, 08/03/11, 06/29/11, 06/08/11, 05/11/11, 04/13/11
Electrodiagnostic study dated 05/13/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. He was electrocuted on his left arm with a 330-volt shock. Electrodiagnostic study dated 05/13/11 revealed bilateral lumbosacral radiculopathy in L2-S2 distribution on the left, and L4-S2 distribution on the right. The patient had lumbar transforaminal epidural steroid injection on 10/24/11. Follow up note dated 11/21/11 indicates that the patient reported pain decreased close to 60%. The patient is noted to be involved in a rehab program. Follow up note dated 12/16/11 states that the injection relieved his pain by more than 85%. Physical examination on 01/13/12 notes that Faber's, Gaenslen's, Yeoman's and straight leg raising are positive bilaterally. Strength is rated as 4/5 throughout the bilateral lower extremities. Sensation to light touch is disturbed in a L5-S1 dermatome fashion.

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

There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient underwent lumbar MRI; however, this study is not submitted for review. The patient reportedly underwent a rehab program; however, there are no progress notes from this program submitted for review. The patient reported 85% pain relief secondary to previous epidural steroid injection; however, duration of relief is not documented, and there is no documentation of decreased medication usage or increased functional ability. At this time, the reviewer finds medical necessity is not established for Bilateral Transforaminal Lumbar ESI L4-S1 and L5-S1 under Anesthesia (#2).

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)