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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/29/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: O/P 2nd lumbar ESI L4-5 under fluoroscopy w/IV sedation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Anesthesiology and 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for an O/P 2nd lumbar ESI L4-5 under fluoroscopy w/IV sedation is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
MRI lumbar spine 03/29/07
Electrodiagnostic studies 07/12/07
MRI right forearm 06/10/08
MRI right wrist 06/10/08
MRI right shoulder 06/10/08
Designated doctor evaluation 09/24/08
Clinical notes 02/16/11-06/05/13
Operative report 04/16/13
Behavioral medicine assessment 04/19/13
Previous utilization reviews 05/21/13 and 06/28/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his low back. MRI of the lumbar spine dated 03/29/07 revealed a broad based posterior central herniated nucleus pulposus producing moderate right and mild left lateral recess narrowing. Electrodiagnostic studies dated 07/12/07 revealed decreased amplitudes in the bilateral medial plantar nerve at the medial malleolus. No other significant findings were noted. Designated doctor evaluation dated 09/24/08 detailed the patient having complaints of low back pain. Clinical note dated 02/16/11 detailed the patient undergoing facet rhizotomy at L4 and L5 and being approved for rhizotomy at L4 and L5. However the patient failed to show for the treatment secondary to transportation issues. The patient continued with low back pain rated as 3-5/10. Tenderness was noted over the L3 through S1 facets at that time. The patient previously underwent medial branch block that reduced the pain by 90%. Clinical note dated 02/01/13 detailed the patient stating that the initial injury occurred when he fell.

The patient previously underwent physical therapy. Operative report dated 04/16/13 detailed the patient undergoing epidural steroid injection at L4-5. Clinical note dated 04/30/13 detailed the patient reporting an 80% improvement in his back pain. Additionally reduction in radiculopathy was also noted. The patient was also more functionally active. The patient was recommended for a second epidural block at that time. Clinical note dated 05/09/13 detailed the patient continuing to report a 70% reduction in pain. The patient rated his pain as 3-4/10. Clinical note dated 06/05/13 detailed the patient continuing with 80% improvement in pain. The patient was walking on a regular basis. The patient had positive straight leg raise on the right at 60 degrees. Sensation was decreased in the L5 distribution.

Previous utilization review dated 05/21/13 resulted in denial as the patient had 23 days of pain relief. However this was insufficient to meet the necessary criteria for repeat epidural steroid injection. Additionally no radicular complaint was noted in the updated clinical notes. Clinical note dated 06/28/13 resulted in denial for a second epidural steroid injection as the patient had five weeks of pain relief; however, no information was submitted of a six week reduction in pain along with objective functional improvement.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: Clinical documentation submitted for review notes the patient complaining of ongoing low back pain with decreased sensation in the lower extremities. Clinical documentation further detailed the patient experiencing a reduction in pain of greater than 70% for approximately five weeks. Official Disability Guidelines recommend repeat epidural steroid injection provided that the patient meets specific criteria, including six to eight week reduction in pain along with objective functional improvement. No information was submitted for completion of a six week reduction in pain following the previous epidural steroid injection. Given this, the request does not meet guideline recommendations. As such, it is the opinion of the reviewer that the request for an O/P 2nd lumbar ESI L4-5 under fluoroscopy w/IV sedation is not recommended as medically necessary.

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)