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IRO Certificate #XX

Notice of Independent Review Decision

DATE OF REVIEW: 7/03/18

IRO CASE NO. XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Lumbar Epidural Steroid Injection at the L4-5 Interspace under Fluroscopy with IV Sedation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified in Anesthesiology & Pain Management

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld **(Agree) X**

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY
Patient is a XX year old individual who sustained a lifting injury in XX with resulting back pain. Imaging showed multi-level bulging discs. After failure of conservative care, XX performed a lumbar epidural steroid injection on XX. On follow-up, XX, 70% pain relief was noted. At the follow-up office visit on XX, there is no documentation of degree of pain relief or increase in functionality, On XX an initial consultation was performed by XX of the XX. At that time, a physical exam revealed decreased reflexes in the left leg. XX describes that the epidural steroid injection "helped for a couple of weeks".

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION
Opinion: I agree with the benefit company's decision to deny the requested service.

Rationale: Previous reviewers denied repeating the ESI due to lack of documentation of pain relief and increased functionality. ODG state that there should be 50 to 70% improvement for 6-8 weeks with **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION** **(continued)** documentation of increased functionality and decreased medication usage. XX documents a "couple of weeks" relief from the ESI. The ODG criteria are not met to approve repeating the ESI; therefore, the requested service is not medically necessary.

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

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)