

SENT VIA EMAIL OR FAX ON
Jul/20/2009

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/14/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral L3/4, L4/5, L5/S1 Lumbar Epidural Steroid Injection with Fluoroscopy

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

Board Certified Orthopedic Surgeon

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

Office notes, Dr. 07/11/07, 02/13/08, 05/21/08, 09/17/08, 01/07/09, 06/06/09, 01/16/08, 06/10/08

Denial 05/06/09, 05/22/09, 06/18/09

Case Notes No Date

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female injured on xx/xx/xx in an unknown manner. There records started in 2007. Diagnoses included L5-S1 anterior and posterior fusion, bowel and bladder incontinence, radiculopathy, obesity and diabetes.

On 07/11/07 Dr. evaluated the claimant noting she was unchanged. He indicated that a myelogram showed stenosis at L2-3, 3-5 and L4-5 with a wide canal at L4-5 and L5-S1. Epidural steroid injection at L3-4 and 4-5 was recommended. This request was denied.

The 05/21/08 visit with Dr. indicated the claimant had last been seen on 07/007. She had been using a diaper and had done so for 3-4 years due to incontinence of stool and bladder. There was noted profound lower extremity weakness. On examination she had positive straight leg raise on the right at 60 degrees and on the left at 75 degrees. She had absent

reflexes at the knees and ankle and abnormal two points. There was weakness of the right extensor hallucis longus at 1/5 and 2-3/5 on left with absent right dorsiflexion and negligible plantar flexion on the left.

On 09/17/08 Dr. noted the claimant had fallen and had a laceration of the right leg that was treated in the ER. He felt the fall was due to radiculopathy.

By 01/07/09 Dr. noted the claimant had lost weight. Reflexes were absent at the knees and ankles. Straight leg raise was positive bilaterally. He noted the claimant had continence, central stenosis at L3-4, 4-5 and L5-S1, incapacitating low back pain, obesity, diabetes type II, radiculopathy and sleep apnea. At that time he recommended medications and injections. The injections have been denied but Dr. has continued to request them to try to relieve some of the claimant's symptoms.

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

Based on review of the records provided and evidence-based medicine, the Reviewer cannot recommend the proposed procedure be considered medically indicated and necessary at this juncture. It is unclear that the claimant has radiculopathy, which has been documented by physical examination and corroborated by imaging studies. Unclear if there has been recent CT scans or myelopathy or MRI scans. Unclear if there has been an EMG/NCS to confirm the reported symptomatology and address confounding issues including diabetic neuropathy and obesity.

Further unclear if the claimant is doing a home exercise program, has recently done physical therapy, stretch, strength, range of motion, modalities, or taken anti-inflammatory medication, or muscle relaxants. A request has been made for three level injection, although per ODG guidelines, the recommendation is for no more than two nerve root levels injected using foraminal blocks.

Official Disability Guidelines Treatment in Worker's Comp 2009 Pain

Indications for the use of Epidural steroid injections

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit

- 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing
- 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)
- 3) Injections should be performed using fluoroscopy (live x-ray) for guidance
- 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections
- 5) No more than two nerve root levels should be injected using transforaminal blocks
- 6) No more than one interlaminar level should be injected at one session
- 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)

- 8) Current research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections
- 9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)