

SENT VIA EMAIL OR FAX ON
Jun/19/2009

True Resolutions Inc.

An Independent Review Organization
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DATE OF REVIEW:

Jun/19/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

ESI Spine

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

MRI Report: 03/17/08

Office Note, Dr.: 05/08/08, 06/24/08, 09/16/08, 10/23/08, 11/20/08, 03/03/09, 04/21/09, 05/07/09, and 05/26/09

Peer Review: 05/04/09, and 05/27/09

Letter, Dr. 05/21/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a reported low back injury on after a fall. Lumbar MRI evaluation on 03/17/08 noted mild spondylosis with mild congenital central canal narrowing, mild degenerative facet disease and mild annular bulges at L4-5 and L5-S1. On 05/08/08 the claimant also noted mild right lateral leg pain. Reference was made to treatment with work restrictions and physical therapy. Cervical and lumbar radiographs on 05/08/08 noted diffuse degenerative changes without evidence of fracture. Lumbar injection was recommended. On 06/24/08 the claimant noted right posterior thigh pain that did not go to the knee. Injections continued to be requested. On 10/23/08 Dr. reported the claimant was twenty percent better after injections without any details provided. Soma was started and facet injections were recommended. On 11/20/08 the claimant continued to complain of low back pain without radiation. Physical examination noted left gastroc weakness at 4/5 with intact sensation and reflexes. Facet and transforaminal injections were recommended.

On 03/03/09 Dr. indicated that two injections helped slightly with the third being denied. Reference was made to facet and transforaminal injections. Physical examination noted normal gait with 5/5 strength, no atrophy, limited motion, normal reflexes and intact sensation. Transforaminal injections times three at L4-5 and L5-S1 were recommended. On 04/21/09 it was noted the claimant continued to treat with Soma, Vicodin, Lexapro and Plavix. Physical examination remained intact. A lumbar caudal injection was recommended and denied. On 05/26/09 the claimant also noted bilateral hip pain with no changes in examination noted. Medications were continued and caudal injections times three were recommended again. The injections were denied. Recommendation continues for caudal lumbar injection.

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

The requested epidural steroid injection is not medically necessary based on review of this medical record. This is a claimant who has back and leg complaints, but there is no documentation in the medical record of an ongoing objective abnormality such as neurologic deficit or muscle atrophy. The claimant has undergone an MRI documenting some mild degenerative changes, but does not appear to have nerve root impingement or disc herniation. ODG guidelines document the use of an epidural steroid injection in patients who have a disc herniation with nerve root abnormality and positive neurologic findings. None of that appears to be the case in this claimant. Therefore, the requested epidural steroid injection is not 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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