

SENT VIA EMAIL OR FAX ON
May/28/2010

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 caudal injection

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

Operative report, Dr., 02/06/03, 07/09/04

MRI lumbar spine, 04/08/03

CT lumbar spine, 05/20/04

Office notes, Dr., 10/25/04, 02/02/05, 08/22/07, 06/18/08, 08/20/08, 11/17/08, 12/17/08, 01/21/09, 03/06/09, 03/20/09, 04/24/09, 05/22/09, 11/25/09, 12/28/09, 03/29/10, 04/30/10

CT scan lumbar spine, 04/27/07

Discharge summary, Dr., 10/31/07-11/03/07

CT lumbar spine, 02/17/09

Lumbar MRI, 04/07/09

Peer review, Dr., 04/12/10

Peer review, Dr., 05/14/01

PATIENT CLINICAL HISTORY SUMMARY

This is a male who was status post L4-S1 fusion in 2003. The CT of the lumbar spine from

02/17/09 revealed grade 1 anterolisthesis of L5 on S1. Two bone graft cages had been placed obliquely from the anterior margin of L5 across the L5-S1 intervertebral disc space into the body of the sacrum to the right of midline. There was fixation with rod and pedicle screws spanning L4-S1. Intervertebral fusion graft is present. L4-5 appeared well incorporated. L4 bilateral pedicle screws were in good position and were intact. The MRI of the lumbar spine from 04/07/09 showed laminectomy and fusion at L4-S1, wide patency of the canal through the operated levels and grade 1 anterolisthesis of L5 on S1 was contributing to marked bilateral foraminal impingement. A somewhat dysplastic vertebral body was designated at L5. Dr. has followed the claimant since at least 2003. On 04/30/10, the claimant reported lower extremity radicular pain, which extended along the plantar aspect of both feet, which he has not had before. The most recent exam on 04/30/10 documented lumbar spine pain exacerbated on both flexion and extension and tilt, decreased sensation along the left lateral thigh and left lateral lower leg, hyperesthesias on the lateral aspect of the foot and positive left straight leg raise. Diminished left patellar and absent left Achilles reflex was noted. Diagnosis was lumbago, lumbar spondylotic spondylolisthesis and lumbar radiculopathy. The claimant has been treated with Medrol dose pack, Soma, Relafen, off work, Ultram, Lyrica and physical therapy.

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

This is certainly a claimant with chronic issues who has undergone prior laminectomy and fusion. Some foraminal encroachment is appreciated. However, there do not appear be clear-cut persistent neurologic deficits. It must be noted that some of the findings documented can be present indefinitely, after surgical intervention and do not necessarily suggest active radiculopathy. Based on a careful review all the information provided the IRO reviewer's medical assessment is that the request is not medically necessary.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter low back, epidural steroid injection

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)