

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/16/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

LESI Caudal

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

Board Certified Anesthesiologist/Pain Management

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

1. Cover sheet and working documents
2. Physical therapy progress notes
3. MRI lumbar spine without contrast dated 03/04/11
4. Progress notes dated 03/10/11-06/01/01
5. Radiographic report lumbar spine dated 03/29/11
6. Utilization review determination for request dated 06/14/11
7. Utilization review reconsideration / appeal of adverse determination for appeal request dated 07/21/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xxxx. On this date the patient slipped and fell. Diagnoses are listed as right wrist fracture, lumbar contusion/strain/sprain and right rib fractures. The patient completed a course of 18 sessions of physical therapy to the right wrist. MRI of the lumbar spine dated 03/04/11 revealed diffuse disc bulges at multiple levels going primarily towards the left at L3-4. It was noted that it could be a left lateral foramina and far lateral disc protrusion, likely disc herniation/extrusion variety, which abutted the exiting nerve root. There is a large diffuse disc bulge at L4-5 and a diffuse disc bulge and superimposed left paracentral to leftward far lateral protrusion at L5-S1 that abutted and could efface the exiting nerve root. There was moderate facet arthropathy noted at multiple levels. Follow up note dated 03/10/11 indicates that the patient's primary complaint continues to be his low back. There are no sensory deficits or paresthesias. The patient has been approved to undergo physical therapy for the low back. Physical examination on

03/29/11 notes that sensation is intact and deep tendon reflexes are normal. Follow up note dated 06/01/11 reports strength is rated as 5/5. Sensation is intact. Straight leg raising is positive and deep tendon reflexes are normal. The patient completed a course of 11 sessions of physical therapy for the lumbar spine.

Initial request for LESI caudal was non-certified on 06/14/11 noting that the most recent note mentions only low back pain, there is no mention or description of symptoms of radiculopathy in a specific radicular pattern, there is no mention of objective findings of radiculopathy, imaging does not specifically describe neurocompression. The denial was upheld on appeal dated 07/21/11 noting that the records do not reflect objective documentation of radiculopathy. There is evidence of degenerative disc disease in the lumbar spine without significant neural impingement or canal compromise or nerve root impingement to support the necessity of epidural steroid injection.

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

Based on the clinical information provided, the request for LESI caudal is not recommended as medically necessary, and the two previous denials are upheld. The patient's physical examination fails to establish the presence of active lumbar radiculopathy as required by the Official Disability Guidelines, and the submitted MRI does not support the diagnosis. Physical examination on 06/01/11 notes that strength is rated as 5/5. Sensation is intact and deep tendon reflexes are normal. Given the lack of documented radiculopathy, the requested epidural steroid injection is not indicated 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)