

Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/15/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Transforaminal epidural steroid injections at the right L4 and L5 with IV sedation, contrast and fluoroscopy

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

MD, Board Certified Anesthesiologist

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

Official Disability Guidelines
Progress notes 12/08/10-04/27/11
MRI lumbar spine dated 12/15/10
Peer reviews Dr. dated 01/13/11 and 04/12/11
Patient treatment plan 02/28/11
Notification of determination physical therapy 3x4 dated 03/03/11
Request for reconsideration for physical medicine and rehabilitation D.C. dated 03/08/11
Pain management consultation dated 05/18/11
Repo rot medical evaluation / designated doctor evaluation dated 05/27/11
Utilization review request for transforaminal epidural steroid injections at right L4 and L5 with IV sedation, contrast and fluoroscopy dated 06/02/11
Letter of reconsideration dated 06/29/11
Utilization review appeal request for transforaminal epidural steroid injections at right L4 and L5 with IV sedation, contrast and fluoroscopy dated 07/08/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. The patient was injured when pulling a wagon containing tail rotors and he strained his lower back. Progress note dated xx/xx/xx reports assessment of thoracolumbar strain and cervical pain. MRI of the lumbar spine dated 12/15/10 revealed 2-3 mm central disc bulge at L4-5 with marginal impression on anterior dura but no impression on the origin of the nerve roots. At L5-S1 there is a 3 mm central disc bulge with no impression on dura and no impression on the origin of the nerve roots. Peer review dated 01/13/11 indicates that the compensable diagnosis is simply a soft tissue myofascial strain of the paravertebral musculature of the lumbar region of the spine. The natural sequelae would be for this to resolve within a 3-6 week time frame. Treatment will

include PT and NSAIDs. Completion of a PT protocol of 6-12 sessions would be supported. Follow up note dated 04/27/11 indicates that on physical examination straight leg raising is negative on the left and positive on the right at 75 degrees. Sensory exam notes decreased sensation along lateral thigh, lateral and posterior calf, heel and lateral foot of right lower extremity. Deep tendon reflexes are +2/4 left patella and bilateral Achilles and +1-2/4 on the right patella. Designated doctor evaluation dated 05/27/11 indicates impression of lumbar sprain/strain and lumbar muscular guarding/myospasms. The patient was determined to have reached MMI as of 05/27/11 with 5% whole person impairment.

Peer review on 06/02/11 stated that the physical examination noted tenderness over the spinous processes and facet joints which confound the clinical presentation. The lumbar MRI does not demonstrate nerve root involvement or impingement at these levels. Active rehabilitative efforts may not have been maximized with only two PT sessions being documented with progress notes. Maximized pharmacotherapy was not substantiated with pain and symptom logs with medication use. The denial was upheld on 07/08/11 with peer reviewer noting that the latest physical examination reported 5/5 lower extremity strength and negative bilateral straight leg raising which are inconsistent with radiculopathy. Active rehabilitative efforts have not been maximized.

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

The submitted records fail to establish that the patient has been unresponsive to conservative treatment as only two physical therapy progress notes were submitted for review. The patient's MRI of the lumbar spine fails to support a diagnosis of radiculopathy as required by the Official Disability Guidelines prior to the performance of lumbar epidural steroid injection. Given the clinical data that was available for review, the requested 1 Transforaminal epidural steroid injections at the right L4 and L5 with IV sedation, contrast and fluoroscopy 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)