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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/25/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L2 transforaminal epidural steroid injection

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

M.D., Board Certified Physical Medicine and Rehabilitation

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

Utilization review determination dated 10/10/11, 11/04/11

Handwritten progress report dated 10/13/11

Initial consultation dated 09/22/11

Patient health questionnaire dated 09/19/11

Lumbar MRI dated 04/19/11

EMG/NCV dated 09/01/11

Handwritten note dated 08/25/11

Designated doctor evaluation dated 10/24/11

Visit summary dated 04/14/11, 04/06/11, 03/31/11, 04/27/11, 05/02/11, 05/09/11, 05/20/11

MA/Nurse notes dated 03/31/11, 04/06/11, 04/18/11, 04/14/11, 04/27/11, 04/22/11, 05/02/11, 05/09/11, 05/20/11

Daily clinical notes dated 07/22/11

Daily therapy treatment note dated 04/07/11, 04/06/11

Peer review dated 09/29/11

Exercise flow chart

Consultation dated 06/06/10, 06/06/11

Preauthorization request dated 06/29/11, 08/16/11, 07/06/11, 09/07/11

Clinical progress daily notes dated 08/29/11, 09/26/11, 06/27/11, 07/12/11, 10/17/11, 10/10/11, 07/18/11, 07/15/11, 07/20/11, 08/03/11, 07/27/11, 07/25/11, 08/01/11, 08/05/11, 08/11/11, 08/10/11, 09/19/11, 09/12/11, 09/06/11

Documentation of procedure letter dated 08/19/11, 08/15/11, 09/12/11

Second opinion dated 06/06/11

Initial narrative report dated 06/22/11

Handwritten note dated 06/30/11, 07/28/11, 10/13/11, 08/25/11

Left shoulder MRI dated 04/29/11

Cervical MRI dated 04/19/11

Reevaluation narrative report dated 06/22/11, 07/05/11, 08/15/11

Functional capacity evaluation summary dated 06/24/11, 08/22/11

Letter of medical necessity dated 07/28/11

Office visit note dated 06/09/11, 05/27/11, 06/27/11, 06/23/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped and fell. Lumbar MRI dated 04/19/11 revealed broad based central disc herniation measuring approximately 6 mm at L2-3; flattening of the thecal sac was noted; mild hypertrophic facet arthropathy is demonstrated; neural foramina are patent.

Functional capacity evaluation dated 06/24/11 indicates that current PDL is sedentary and required PDL is heavy. Functional capacity evaluation dated 08/22/11 indicates that that current PDL remains sedentary. Clinical progress daily notes dated 08/29/11 indicate palpation revealed muscle spasms as well as tenderness in the cervicothoracic and lumbar spine and paraspinal areas bilaterally. Range of motion is restricted globally moderately secondary to pain in the above mentioned areas. EMG/NCV dated 09/01/11 revealed no electrophysiological evidence of lumbar radiculopathy. Initial consultation dated 09/22/11 indicates that the patient complains of low back pain that radiates down the left leg and neck pain that radiates down the left arm. Past surgical history is negative. Current medications include Norco and Zanaflex. On physical examination lumbar range of motion is decreased in flexion and extension with spasm and tenderness in the lumbar paraspinal muscles. Sensation is intact to light touch. Motor exam revealed 5/5 strength. Deep tendon reflexes were 2+ and symmetric. Straight leg raising is positive on the left side sitting at 30 degrees. Clinical progress daily notes dated 09/26/11 indicate physical examination is unchanged from 08/29/11. Peer review dated 09/29/11 indicates that the reviewer would try epidural steroid injections and assess how they benefit him. It appears that the patient's injury is a sprain and strain injury, but he does complain of ongoing pain. The patient should reach MMI in approximately 3 months. Designated doctor evaluation dated 10/24/11 indicates that treatment to date includes physical therapy, medication management, diagnostic testing and chiropractic care. Medications are listed as Hydrocodone, Flexeril, Valium and Ativan. Diagnoses are cervical sprain/strain, lumbar sprain/strain, shoulder sprain/strain and ankle sprain/strain. The patient was determined to have reached MMI as of 06/30/11 with 0% whole person impairment.

Initial request for L2 transforaminal epidural steroid injection was non-certified on 10/10/11 noting that there is no specific description of pain in a clear radicular pattern. There is no mention of objective findings of radiculopathy. Imaging shows no neurocompression, fracture or instability. The denial was upheld on appeal dated 11/04/11 noting that clinical findings on physical examination are not consistent with an objective focal neurologic deficit in a dermatomal or myotomal pattern that would cause concern for neural compromise or radiculopathy stemming from the lumbar spine. The electrodiagnostic study was negative.

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 L2 transforaminal epidural steroid injection is not recommended as medically necessary. The patient's physical examination does not establish the presence of active lumbar radiculopathy, and the submitted MRI and EMG/NCV do not support the diagnosis. Per designated doctor evaluation dated 10/24/11, the patient's diagnoses consist of multiple sprain/strain injuries. The patient was determined to have reached maximum medical improvement as of 06/30/11 with 0% whole person impairment. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

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)