

SENT VIA EMAIL OR FAX ON
Feb/15/2011

Applied Assessments LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Feb/14/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
TESI L4-5 Bil (done in office)

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

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

PATIENT CLINICAL HISTORY SUMMARY

The patient is a xx-year-old male. The patient injured his lower back when he slipped and fell. MRI of the lumbar spine dated 01/04/06 revealed an annular disc bulge at L3-4 that flattens the thecal sac with mild central canal stenosis and mild bilateral foraminal narrowing. At L4-5 there is a 4 mm subligamentous disc herniation indenting the adjacent thecal sac with mild canal stenosis; impingement upon the L5 nerve root sleeves is seen; mild bilateral foraminal encroachment is identified.

There is a gap in treatment records until designated doctor evaluation dated 04/29/09. The patient was determined to have reached maximum medical improvement as of 12/19/07 with 10% whole person impairment. Treatment to date is noted to include diagnostic testing, physical therapy and medication management.

EMG/NCV of the lower extremities dated 11/11/09 revealed evidence of multilevel radiculopathy at with involvement of L4, L5 and S1 distributions. The patient subsequently underwent transforaminal epidural steroid injection at L4-5 bilaterally on 06/16/10. Follow up note dated 11/11/10 indicates that the patient's medications include Tramadol, Celebrex and Lovitra. On physical examination range of motion is decreased. Straight leg raising reveals no change. Reflexes are 1+ throughout the bilateral lower extremities with the exception of trace left Achilles. The patient has gotten symptomatically worse to the point that he is unable to walk for more than two blocks without getting severe dysesthesias in his left leg.

A request for repeat lumbar epidural steroid injection was non-certified on 12/15/10 noting that there is no documentation that conservative therapy has been optimized. There is a lack of information regarding the patient's response to the previous epidural steroid injection. The denial was upheld on appeal on 01/14/11 noting that there is no change in sitting straight leg raising. There are no PT progress notes to show the patient's clinical and functional response as well as documentation of pharmacotherapeutic use. There is no documentation of the patient's response to the previous epidural steroid injection.

Medical records review dated 01/20/11 indicates that overall treatment to date has been reasonable, necessary and related to the compensable injury and notes that the patient's injury has stabilized.

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 transforaminal epidural steroid injection L4-5 bilaterally is not recommended as medically necessary. The submitted records indicate that the patient underwent previous transforaminal epidural steroid injection at L4-5 bilaterally on 06/16/10; however, the patient's objective, functional response to this injection is not documented. The Official Disability Guidelines support repeat epidural steroid injections only with evidence of at least 50-70% pain relief for at least 6-8 weeks. Given the current clinical data, the requested transforaminal epidural steroid injection L4-5 bilaterally is not recommended as medically necessary and the previous denials are 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)