

SENT VIA EMAIL OR FAX ON
Jan/25/2011

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/20/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar ESI L5-S1

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

The submitted medical records include the cover sheet and working documents, encounter notes M.D. dated 08/23/10-01/06/11, Company response regarding disputed services dated 01/11/11, utilization review determination dated 11/29/10, 12/17/10, 10/01/10, follow up note dated 08/16/10, 08/09/10, 07/26/10, MRI of the lumbar spine dated 08/06/10, and therapy progress note dated 11/17/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient tripped and fell on his low back. The patient has a history of an L4-5 lumbar laminectomy in 2005. MRI of the lumbar spine dated 08/06/10 revealed an extruded disc at L5-S1 seen to the left of midline that measures 8 mm transverse x 6 mm AP x 21 mm craniocaudal; this extends along the dorsal aspect of the S1 vertebral body. This creates mass effect upon the left aspect of the thecal sac and appears to contact the descending nerve roots. There is moderate right neural foraminal narrowing and severe left neural foraminal narrowing.

Encounter note dated 07/26/10 at Clinic indicates that straight leg raising is negative bilaterally. There is no sensory deficit and deep tendon reflexes are 2+ throughout the bilateral lower extremities. Assessment is lumbosacral contusion and left leg pain. The patient was provided medications, warm compresses, home exercises and returned to work light duty.

Initial encounter note with Dr. M.D. dated 08/23/10 indicates that reflexes are 1/2 with the knees and absent at both ankles. Sensation is diminished in the lateral calf below the left knee into the lateral foot. Motor strength is normal in both legs. Straight leg raising on the left exacerbates the buttock pain and on the right is pain-free.

The patient underwent initial left L5-S1 epidural steroid injection on 09/13/10. Follow up note dated 09/27/10 indicates that the patient's left leg pain has improved with the injection, but he still has low back pain radiating through the left buttock. Follow up note dated 10/14/10 indicates that the patient reports 50% improvement in pain. This note indicates that the patient has not undergone physical therapy. On physical examination straight leg raising on the left is now negative.

Therapy progress note dated 11/17/10 indicates that the patient has completed 7 physical therapy visits to date with minimal progress. He does report slightly less left lower extremity pain.

Encounter note dated 11/18/10 indicates that physical therapy has not helped and the patient's pain improved for six weeks following his first epidural steroid injection. On physical examination straight leg raising is pain-free.

The initial request for lumbar epidural steroid injection was non-certified on 10/01/10 noting a lack of documented radiculopathy. The reviewer noted that there is no documentation of failure of conservative treatment to include medication management and physical therapy. The patient's previous back surgery is considered a negative factor for the success rate of the contemplated injection. The clinical information did not provide objective documentation of the patient's clinical and functional response from the previous epidural steroid injection. The records also indicate that the patient is obese with BMI of 33.2.

The request was again non-certified on 11/29/10. The reviewer noted that no procedure report was provided regarding the previous epidural steroid injection, and there is no documentation as to the degree of relief. There is also no mention with regard to increased functionality as well as decreased medication intake following the initial injection. PT progress reports documenting compliance and functional response to therapy were not provided. The patient is obese with BMI of 37.7. The previous back surgery is also considered a negative predictor of success of the contemplated injection.

The non-certification was upheld on appeal dated 12/17/10. The reviewer notes that the submitted records did not provide objective documentation of increased performance in ADLs and reduction of medication use with the previously rendered injection.

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

Based on the clinical information provided, lumbar epidural steroid injection L5-S1 is not recommended as medically necessary, and the previous denials are upheld. The patient underwent initial epidural steroid injection on 09/13/10 and noted 50% pain relief for one month. The Official Disability Guidelines support repeat epidural steroid injection only with evidence of at least 50-70% pain relief for at least 6-8 weeks. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. The submitted records fail to establish that the patient sustained continued objective pain relief for 6-8 weeks. There is no documentation of decreased need for pain medications, and the patient's functional response to the injection is not documented. Additionally, negative predictors of success include the patient's body habitus and previous

lumbar surgery. Given the current clinical data, the requested epidural steroid injection is not 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)