

SENT VIA EMAIL OR FAX ON
Mar/07/2011

Pure Resolutions Inc.

An Independent Review Organization
990 Hwy 287 N., Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 349-6420
Fax: (512) 597-0650
Email: manager@pureresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Mar/04/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Transforaminal Epidural Steroid Injection L4/5 Bilaterally

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

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 on a kitchen floor, landing on his lower back. Treatment to date is noted to include physical therapy, medication management, trigger point injections, ultrasound and chiropractic treatments. Follow up note dated 09/11/07 indicates that the patient was seen and treated by a Dr. who did some epidural steroids over a period of several months. The

patient stated that ESIs helped him very little. Diagnosis is reported as low back pain, etiology undetermined.

MRI of the lumbar spine dated 02/19/09 revealed status post fusion L5-S1 with laminectomy defect and scarring about the thecal sac and nerve roots; moderate spondylosis change mid lumbar spine greatest at L4-L5 with disc protrusion, ligamentum flavum, and facet hypertrophy causing mild central spinal stenosis, lateral recess stenosis and bilateral neural foraminal narrowing.

Follow up note dated 09/17/09 indicates that on physical examination there is no gross motor or sensory loss. Deep tendon reflexes are bilaterally active and equal. The patient is reported to have undergone decompression and stabilization with transpedicular fixation and arthrodesis at L5-S1 on 07/18/08.

EMG/NCV dated 10/28/09 revealed an indication of acute and chronic radiculopathy in the bilateral L4, L5 and S1 motor roots with some more chronic changes appearing in the L5 distributions and with the left L4 showing the greatest acute changes. Follow up note dated 11/19/09 indicates that surgical recommendation is a decompression and stabilization of the L4-5 segment.

Follow up visit dated 01/06/10 reports on physical examination straight leg raising is negative. Deep tendon reflexes are 2+ on the right and 1+ on the left. Strength is equal bilaterally. Sensation is intact in all the lower extremity dermatomes. The patient was recommended for CT scan, psychosocial evaluation, and physical therapy. Follow up note dated 11/16/10 indicates that the patient continues with low back pain with associated numbness and tingling in the lower extremities. Medications include Hydrocodone, Lexapro, Albuterol inhaler, Soma and Seroquel. The patient was provided a Toradol injection on this date and was recommended to undergo MRI of the lumbar spine.

Initial request for transforaminal epidural steroid injection L4-5 bilaterally was non-certified on 02/02/11 noting a lack of documentation regarding failure of conservative treatment, and no clear objective evidence of radiculopathy. The denial was upheld on 02/17/11 noting that there is no documentation indicating why this injection is being requested or a definitive diagnosis.

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, and the two previous denials are upheld. The patient sustained injuries in xx/xx/xx; however, the mechanism of injury is not documented. There is no comprehensive assessment of recent treatment completed to date or the patient's response thereto submitted for review. The patient's physical examination fails to establish the presence of active lumbar radiculopathy. The patient reported that he underwent previous epidural steroid injections with Dr. and reports that epidural steroid injections helped him very little. Given the current clinical data, the requested transforaminal epidural steroid injection L4-5 bilaterally is not indicated as medically necessary, and the two 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)