

SENT VIA EMAIL OR FAX ON  
May/11/2011

## True Resolutions Inc.

An Independent Review Organization  
500 E. 4th St., PMB 352  
Austin, TX 78701  
Phone: (214) 717-4260  
Fax: (214) 276-1904  
Email: rm@trueresolutionsinc.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

May/11/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar Epidural Block/Facet Injection @ L4-5

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

Board Certified Neuro 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

1. Cover sheet and working documents
2. Utilization review determination dated 03/07/11, 03/28/11
3. Office visit note dated 04/26/11, 04/21/11, 03/29/11, 03/15/11, 03/01/11, 02/15/11
4. MRI lumbar spine dated 02/08/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was involved in a motor vehicle accident. He was hit on the passenger side, after which the patient started having pain in his low back. MRI of the lumbar spine dated 02/08/11 revealed annular tears at L2-3 and L4-5. At L5-S1 there is a right paracentral/foraminal broad based protrusion containing an annular tear, elevating the thecal sac, resulting in mild right lateral recess stenosis; where the disc touches the right S1 nerve root, and moderate right foraminal stenosis; where there is mild compression of the right L5 nerve root. Office visit note dated 03/01/11 indicates that there is tenderness to the low lumbar region, sensation is normal, reflexes are equal and symmetrical. Straight leg raising is 80 degrees bilaterally. The patient was recommended to continue taking medications and for epidural pain block and facet block of L4-5.

Initial request for lumbar epidural block/facet injection at L4-5 was non-certified on 03/07/11 noting that epidural steroid injection and facet injections are not recommended to be performed at the same time. There is no indication that the epidural steroid injection is part of an evidence based rehabilitative plan aimed at restoration of function and avoidance of surgery. There is no documentation of failure of conservative treatment. The denial was upheld on appeal dated 03/28/11 noting there is no documentation of associated findings

such as loss of relevant reflexes, muscle weakness and/or atrophy of appropriate muscle groups. There is no documentation of low back pain that is non-radicular.

**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 lumbar epidural block/facet injection at L4-5 is not recommended as medically necessary, and the two previous denials are upheld. The requests are contradictory as the Official Disability Guidelines support epidural steroid injection for patients with documented radiculopathy, and facet injections are supported for patients with non-radicular low back pain. There is no comprehensive assessment of treatment completed to date and the patient's response thereto submitted for review. There is no indication that the patient has undergone an appropriate course of physical therapy as recommended by the guidelines. The patient's physical examination fails to establish the presence of active lumbar radiculopathy or facet-mediated pain.

**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 KNOWLEDGBASE

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)