

SENT VIA EMAIL OR FAX ON
Apr/27/2011

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:
Apr/26/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Second Lumbar Transforaminal Epidural Steroid Injection Left L5 under Fluoroscopy and Sedation

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

1. Cover sheet and working documents
2. Utilization review determination dated 04/04/11, 04/12/11
3. Office visit note dated 03/24/11, 01/13/11, 01/06/11, 09/21/10, 09/01/10
4. MRI lumbar spine dated 01/07/11
5. MRI cervical spine dated 08/09/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx . MRI of the lumbar spine dated 01/07/11 revealed moderate multifactorial central canal and lateral recess stenosis L4-5, descending L5 nerve root compression is seen left greater than right; distal lumbar facet arthrosis L3-4 through L5-S1; no exiting nerve root impingement. Office visit note dated 09/21/10 indicates that the patient had not undergone any PT to date. Office visit note dated 03/24/11 indicates that the patient has been recommended for transforaminal epidural steroid

injection. Medications include Lopressor and Skelaxin. On physical examination lumbar range of motion is restricted. Muscle strength is intact and symmetrical in the bilateral lower extremities. There is hypoesthesia in the left L5 and S1 distribution. Deep tendon reflexes are 2+ throughout the lower extremities. Straight leg raising is positive on the left.

Initial request for second lumbar epidural steroid injection left L5 under fluoroscopy and sedation was non-certified on 04/04/11 noting that the initial epidural steroid injection has been approved but not performed. A second epidural steroid injection cannot be approved until response to the initial injection is noted. The denial was upheld on appeal dated 04/12/11 noting that no imaging is available for review, and the patient has not yet had the first epidural steroid injection.

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 second lumbar transforaminal epidural steroid injection left L5 under fluoroscopy and sedation is not recommended as medically necessary, and the two previous denials are upheld. The patient has been approved to undergo initial epidural steroid injection; however, it is unclear if this injection has been performed yet, and if so, the patient's objective, functional response to the injection is not documented. 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. A second epidural steroid injection cannot be authorized until the results of the initial injection are documented.

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)