I-Resolutions Inc.
An Independent Review Organization
8836 Colberg Dr.
Austin, TX 78749
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/13/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Transforaminal Epidural Steroid Injection left L5 & S1

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Anesthesiologist

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines
MRI lumbar spine 03/17/10
Musculoskeletal exam and neurosurgical consultation 01/19/11 MD
Letter 03/04/11 MD
MRI lumbar spine 02/16/11
Fax cover sheet 02/21/11 requesting pre-determination for transforaminal epidural steroid injection
Fax cover sheet 03/14/11 requesting pre-authorization for transforaminal epidural steroid injection
Pre-authorization review 02/28/11
Reconsideration/appeal pre-authorization review 03/18/11

PATIENT CLINICAL HISTORY SUMMARY
The injured employee is a male whose date of injury is xx/xx/xx. Records indicate the injured employee was moving portable set up steps and while leaning forward felt an audible pop in his back creating a burning cramp in the low back to the knee on the left side. MRI of the lumbar spine dated 03/17/10 revealed moderate degenerative disc disease at L5-S1 with generalized disc bulging which extends to the left and produces moderate left neural foraminal stenosis. There is no disc protrusion or spinal canal stenosis noted. The other levels demonstrate mild degenerative disc disease without evidence of disc protrusion or spinal canal stenosis. Repeat MRI of the lumbar spine on 02/16/11 revealed minimal left paracentral disc protrusion at L4-5 with no significant nerve root abutment, otherwise negative MRI of the lumbar spine. The injured employee was seen for neurosurgical opinion on 01/19/11 with complaints of low back pain and left leg pain. The injured employee was noted to have undergone epidural steroid injections on one occasion, which helped for perhaps two weeks. The injured employee was noted to have tried physical therapy. An EMG reportedly was normal, but no report of this study was included. On examination the injured employee was noted to weigh 322 pounds, but height was not documented. Gait and station were normal with good tandem. Romberg was negative. There was normal flexion

and extension. Motor strength was 5/5 throughout. Deep tendon reflexes were 2+ in all extremities. There were no pathologic reflexes. There was no clonus. Sensation was intact and symmetric in the bilateral upper extremities and bilateral lower extremities. A request for L5-S1 epidural steroid injection was determined as not medically necessary on 02/28/11. It was noted that ODG guidelines clearly state radiculopathy must be documented to warrant epidural steroid injections. There was no documentation of radiculopathy by EMG. There were no motor or sensory deficits documented and therefore the request was non-certified.

A reconsideration/appeal request for transforaminal epidural steroid injection left L5 and S1 was determined as not medically necessary on 03/18/11. It was noted that documentation did not support effectiveness of previous epidural steroids such as decrease on pain score greater than 50% relief for six to eight weeks, increase in activity, increase in function, increase in sleep, return to some form of vocation, decrease medical visits.

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

This injured employee is noted to have sustained injury to the low back on xx/xx/xx. Imaging studies revealed minimal left paracentral disc protrusion at L4-5 with no significant nerve root abutment. EMG was noted to be a normal study with no evidence of radiculopathy. Physical examination findings revealed no motor, sensory or reflex deficits. The records also indicate the injured employee had previous epidural steroid injection which helped only for perhaps two weeks, with no quantification of the amount of relief obtained. Per ODG guidelines radiculopathy must be documented with objective findings present on examination and corroborated by imaging studies and/or electrodiagnostic testing. The guidelines further reflect that repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, functional response with at least 50% pain relief last six to eight weeks. The clinical data provided does not fulfill the criteria outlined in ODG, and medical necessity is not established. The reviewer finds there is no medical necessity at this time for Transforaminal Epidural Steroid Injection left L5 & S1. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be 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
[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
[ ] MILLIMAN CARE GUIDELINES
[X] 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)