

SENT VIA EMAIL OR FAX ON
Nov/09/2011

Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (817) 549-0311
Email: rm@independentresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/08/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient epidural steroid injection at L1/2

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

Request for IRO dated 10/27/11

Clinical records Dr. dated 09/16/10-09/21/11

Radiographic report lumbar spine dated 02/11/11

CT myelogram thoracic and lumbar spine dated 04/08/11

Clinic note Dr. dated 07/13/11

Procedure report lumbar epidural steroid injection on right at L1-2 dated 09/13/11

Utilization review determination dated 10/03/11

Letters of appeal dated 10/06/11 and 10/25/11

Utilization review determination dated 10/14/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who has history of L2-S1 PSF. On 09/16/10 the claimant is noted to have 90 degrees of lumbar flexion, 30 degrees extension, 40 degrees lateral bending bilaterally, normal gait, 5/5 motor strength in lower extremities, reflexes were 3/3, right leg raise is reported to be normal. straight leg raise is negative. Records indicate the claimant was referred for radiographs of lumbar spine on 02/11/11. This study notes the claimant has stable intersegmental and low back metallic and osseous fusion from L2-3 through L5-S1 level. Disc height is adequately maintained except at L1-2 for minor posterior narrowing and minimal anterolisthesis of L1 relative to L2 on flexion. The claimant was referred for thoracic and lumbar myelogram on 04/08/11. This study notes abnormality in the thoracic region at T8-9 where there is shallow extradural defect on myelogram with double density. CT

demonstrates a 2-3 mm diffuse right paracentral protrusion which produces mild ventral dural deformity borderline spinal cord impingement. At T7-8 there is a minimal left paracentral protrusion. There is hemangioma noted in the body of T9. The study of lumbar spine notes postsurgical changes from L2-S1 with fixation, bilateral posterolateral rod and pedicle screw instrumentation. There is a transverse strut at L2-3. There are single metal interbody fusion cages at L2-3, L3-4, L4-5 and L5-S1. There are bilateral laminotomies at L2-3, L3-4, L4-5 and L5-S1 with partial facetectomy more extensive on left at L2-3 and L3-4 and left laminectomy and partial facetectomy at L4-5 and L5-S1. Bilateral posterolateral bony fusion masses are present from L2 caudally. CT does not clearly demonstrate confluence against fusion masses. There is solid integration of metal into the endplates at all the included disc levels and no evidence of metal fatigue or loosening. There is no excursion at levels of fixation demonstrated with flexion / extension views. There is dorsal extra spinal fluid collection at L3 and L4. Above the level of fusion at L1-2 there is probably a slight anterolisthesis. There is a 3 mm disc protrusion. There are also bilateral flavum and facet joint prominences at L1-2 with shallow dorsal impressions on the dural sac. The residual mid sagittal dural diameter on CT is 5-6 mm.

On 07/13/11 the claimant was seen by Dr. for evaluation. It is reported the claimant has complaints of pain at the L1-2 level. On physical examination there is tenderness beginning at T6 extending down the midline to mid lumbar region. Palpation of thoracic spine causes some radiation of pain to the right side. His strength is maintained. Reflexes are 3+ and equal. Sensation appears intact. Straight leg raise is positive. Dr. subsequently suggests the claimant will benefit from L1-2 epidural steroid injection. Records indicate on 09/13/11 the claimant underwent right L1-2 epidural steroid injection. Post procedurally the claimant was seen in follow-up on 09/21/11. Physical examination remains unchanged.

On 10/03/11 the initial request was reviewed by Dr. Dr. notes the claimant has previously been approved for lumbar epidural steroid injection at L1-2, but the date, results and duration of relief is not known. He subsequently non-certified the request.

On 10/16/11 Dr. submitted a letter of appeal noting the recent epidural steroid injections provided excellent pain relief. He reported the patient wishes to pursue more injections because of significant relief he experienced with first injection.

A subsequent appeal request was reviewed on 10/14/11 by Dr. Dr. upheld the previous denial. He notes the claimant has previously undergone epidural steroid injection on 09/13/11 and notes the claimant had excellent pain relief, but his symptoms had returned and wanted another injection. Dr. notes that the claimant would not have met criteria for repeat injection given lack of response and poor duration.

On 10/25/11 Dr. submitted a letter of appeal and reported the claimant received 70% pain relief.

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

The request for epidural steroid injection at L1-2 is opined to be medically necessary. The submitted clinical records indicate the claimant has significant stenosis in findings on physical examination consistent with L1-2 radiculopathy. The claimant underwent a lumbar epidural steroid injection on the right at this level and after multiple reviews was ultimately identified as having 70% relief as result of this injection. Based on the clinical information provided, the claimant meets criteria for performance of second lumbar epidural steroid injection at this level. Based on the clinical information provided, the previous utilization determinations are overturned.

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)