

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/07/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left LESI with fluoro L5-S1

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

Orthopedic spine surgeon, practicing neurosurgeon

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

Notification of adverse determination 07/29/11 non-certifying left LESI with fluoro L5-S1

Notification of reconsideration determination 09/06/11 non-certifying appeal request left LESI with fluoro L5-S1

Office note Dr. 07/21/11

MRI lumbar spine 06/16/11

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male who sustained a lifting injury to low back on xx/xx/xx when he picked up a metal tank cover and experienced onset of severe lumbar pain with radiating pain to bilateral hips and legs. MRI of lumbar spine performed 06/16/11 revealed broad based disc bulges at L3-4, L4-5 and L5-S1. There are no focal disc protrusions or central spinal stenosis at L5-S1. There was disc osteophyte ligament encroachment resulting in bilateral neural foraminal stenosis a little worse on left at L5-S1. There is mild central stenosis at L3-4 and L4-5 and moderate bilateral foraminal stenosis at L3-4 with moderate right and severe left foraminal stenosis at L4-5. Examination performed on 07/21/11 reported the injured employee to be around 6 feet in height and weighs 180 lbs. There was total loss of lumbar lordosis. There was paralumbar muscular tightness, and the injured employee walks with flexed posture at low back. There is tenderness over both sciatic outlets, mainly the left. He has somewhat wide based gait. He has left antalgic gait. There is no pain with hip rotation.

Deep tendon reflexes were 1+ in knees and trace in ankles. Straight leg raise was positive on right at 60 degrees and on left at less than 45 degrees. There was decreased sensation in left L5 and S1 dermatomes across dorsum of lateral foot. There was little weakness of plantar flexion and dorsiflexion on left foot. There were no lower extremity pathologic reflexes. There was no focal muscular atrophy or fasciculations. The injured employee had difficulty getting off the examining table and out of chair because of pain. Physical therapy was recommended as well as lumbar epidural Depomedrol injection.

A utilization review performed on 07/29/11 determined request for left LESI with fluoro L5-S1 as not medically necessary. It was noted the injured employee complaints of lumbar pain that is gradually getting worse. Physical examination revealed total loss of lumbar lordosis, paralumbar muscular tightness, pain with hip rotation, positive straight leg raise bilaterally, and decreased sensation in left L5 and S1 dermatomes. There was also noted weakness of plantar flexion and dorsiflexion of the left foot. MRI on 06/16/11 revealed mild broad based disc bulge at L5-S1 that only slightly encroaches on the thecal sac. There was no electrodiagnostic study available for review. Objective measures of pain relief and functional response to pharmacotherapy was not provided. There was no documentation included of failure of less invasive modalities of conventional treatment to produce clinically significant responses. It was deemed that conservative treatment has not been exhausted, and medically necessary of requested service is not established.

A reconsideration request was reviewed on 09/06/11 and determined as not medically necessary. The reviewer noted there was an adverse determination on previous review. In acknowledgement of previous non-certification due to lack of documentation and failure of conservative treatment, there is now documentation as per latest medical report dated 07/21/11 that the injured employee presented with lumbar pain with bilateral radiation to hip and leg with numbness, dysesthesias, and feeling of weakness in legs. Physical examination showed total loss of lumbar lordosis, paralumbar musculature tightness, pain with hip rotation, positive straight leg raise bilaterally, decreased sensation of left L5 and S1 dermatomes, weakness of plantar flexion and dorsiflexion of left foot, and depressed knee and trace ankle reflexes. MRI showed at L5-S1 disc osteophyte and ligament encroachment resulting in bilateral neural foraminal stenosis a little worse on left. Treatment has included medications. However, there is no documentation that the injured employee has initially been unresponsive to conservative treatment (exercises, physical methods). Therefore, medical necessity has not been substantiated.

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

Based on the clinical information provided, the proposed left lumbar epidural steroid injection with fluoroscopic guidance L5-S1 is not indicated as medically necessary. The injured employee sustained a lifting injury to low back on xx/xx/xx. MRI revealed multilevel disc bulges with no focal disc protrusions. At L5-S1 there is a mild broad based disc bulge that only slightly encroaches the thecal sac without central spinal stenosis. Disc osteophyte ligament encroachment resulted in bilateral neural foraminal stenosis, a little worse on left at this level. Impression was multilevel lumbar spondylitic changes. On examination the injured employee was noted to have motor and sensory deficits on the left in L5 and S1 distribution. The patient had total loss of lumbar lordosis and ambulated with somewhat wide based and left antalgic gait. Other than medications, there is no evidence that the injured employee had any conservative treatment with physical therapy / home exercise program or other conservative care. Per ODG guidelines, epidural steroid injection may be considered to treat radiculopathy in patients who are initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, and muscle relaxants). Noting the absence of appropriate course of initial conservative treatment, the request for left L5-S1 lumbar epidural steroid injection with fluoro was appropriately non-certified on previous reviews.

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)