

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 NOTICE SENT TO ALL PARTIES:

Dec/07/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar ESI #3 at right L5/S1

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

Orthopedic surgery

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Request for IRO 11/16/12

Receipt for request of IRO 11/19/12

Utilization review determination 10/24/12

Utilization review determination 11/06/12

Peer review report 10/23/12

Peer review report 11/05/12

Clinical records Dr. 04/15/11-04/03/12

Clinical note Dr. 05/10/11

Clinical note Dr. 05/10/11-10/10/12

Operative report 05/27/11

Operative report umbilical hernia repair 05/23/11

Operative report anterior exposure 05/27/11

MRI lumbar spine 05/15/12

Procedure report lumbar epidural steroid injection 07/05/12

Letter of appeal 08/15/12

Required medical examination 08/30/12

Clinical note 08/31/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was reported to have a date of injury of. On the date of injury, he was reported to have been struck from behind by an 18 wheeler. He subsequently underwent a course of conservative management for low back pain with radiculopathy and the claimant was ultimately taken to surgery on at which time he underwent an anterior discectomy with decompression at the L4-5 level. Post-operatively the claimant was noted to have made slow progress and imaging studies eventually indicated that the graft was intact. Serial radiographs show consolidation of the fusion and he was noted to have improvement in his lower extremity motor strength. The record included an MRI of the lumbar spine dated which showed no evidence of pathology at L1-2 through L3/4. At L4-5 there were post-operative changes noted related to a fusion procedure. A fixation device was in place. There was mild bulging of the annulus fibrosis with a small central disc extrusion. At L5-S1, there was a degenerative disc with a diffuse disc bulge of the annulus fibrosis and a large right paracentral disc protrusion.

On, the claimant was seen in follow up by Dr.. Dr. opined that the claimant would ultimately require laminectomy discectomy at the L5-S1 level. The claimant was subsequently recommended to undergo a lumbar epidural steroid injection which was performed on 07/05/12. Post-procedurally he was reported to have received 75% relief. The claimant was ultimately approved for a second lumbar epidural steroid injection which was performed on 09/12/12. Post-procedurally, he was again reported to have had 75% relief. A request was made for a third lumbar epidural steroid injection.

The initial review was performed by Dr. on. Dr. non-certified the request, noting that the claimant had two injections with varying reports of success from "a little to 75%". She noted that the last injection was done six weeks ago and there was no updated note indicating whether the patient had a full six weeks or more of benefit from the injection. She noted that neurological examinations have been negative for radiculopathy and found that there was no clinical or historical support for the performance of a third epidural steroid injection.

The appeal request was reviewed by Dr. on. Dr. non-certified the appeal request reporting that, per the independent medical examination submitted for review, there was no significant long term relief from epidural steroid injections and it would be unlikely to alter this course of treatment.

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

The request for lumbar epidural steroid injection # 3 is not supported as medically necessary and the prior utilization review determinations are upheld. The submitted clinical records indicate that the claimant sustained an injury to his low back that ultimately resulted in the performance of an ALIF at the L4-5. Post-operatively the claimant had complaints of low back pain with radicular symptoms. However, serial physical examinations provide no objective evidence of an active lumbar radiculopathy. The submitted post procedure reports note that the claimant had modest relief up to 75%. However, the clinical records do not describe a time period for which the claimant received some form of therapeutic benefit. The Official Disability Guidelines require that there be at least 50% relief for a period of six weeks to justify repeat epidural steroid injections. Further, the Official Disability Guidelines do not support the performance of a series of three lumbar epidural steroid injections. Given the lack of objective findings on physical examination establishing the presence of an active radiculopathy, the request for disability is not supported as medically necessary.

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)