

SENT VIA EMAIL OR FAX ON
May/25/2012

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/23/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Transforaminal Epidural Steroid Injection at the Left L4/5 and L5/S1 Levels under Fluoroscopy

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

PMR

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

01/03/12 – PHYSICAL THERAPY NOTE

01/03/12 – HEALTH INSURANCE CLAIM FORM

01/05/12 – PHYSICAL THERAPY NOTE

01/05/12 – HEALTH INSURANCE CLAIM FORM

01/09/12 – PHYSICAL THERAPY NOTE

01/09/12 – HEALTH INSURANCE CLAIM FORM

02/01/12 – MRI LUMBAR SPINE

02/09/12 – EXPLANATION OF REVIEW

02/16/12 – CLINICAL NOTE – MANOUCHEHR REFAEIAN, MD

03/01/12 – CLINICAL NOTE – MANOUCHEHR REFAEIAN, MD

03/06/12 – CLINICAL NOTE – DAVID HOLLAND, MD

04/17/12 – CLINICAL NOTE – MANOUCHEHR REFAEIAN, MD

04/20/12 – PRE-CERTIFICATION/AUTHORIZATION REQUEST

04/25/12 – UTILIZATION REVIEW DETERMINATION

05/01/12 – APPEAL LETTER

05/01/12 - PRE-CERTIFICATION/AUTHORIZATION REQUEST

05/07/12 – UTILIZATION REVIEW DETERMINATION

05/08/12 – REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION

05/11/12 – NOTICE OF TRUE DECISIONS, INC OF CASE ASSIGNMENT

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained an injury on xx/xx/xx. The claimant attended 3 sessions of physical therapy from 01/03/12 through 01/09/12. The physical therapy note dated 01/09/12 states the claimant was capable of lifting 8 pounds from the floor to the waist, up from 0 pounds, and was capable of lifting 8 pounds from waist to overhead, up from 0 pounds. Lumbar extension was to 12 degrees, with a goal of 15 degrees. There was mild weakness with left hip flexion. The claimant was recommended for 6 additional sessions of physical therapy to address functional and impairment goals. MRI of the lumbar spine performed 02/01/12 revealed a broad-based central 0.5cm disc herniation that indented the thecal sac at L4-5, resulting in mild spinal canal stenosis. At L5-S1, there was a broad-based 0.5cm disc herniation that indented the thecal sac and touched the S1 nerve roots with possible mass effect. Disc herniation and loss of disc height contributed to moderate right and mild left neural foraminal narrowing.

The claimant saw Dr. on 02/16/12 with complaints of low back pain with radiation down the bilateral lower extremities, left greater than right. The claimant rated the pain at 4 out of 10, with an increase to 8 out of 10 with activity. Physical exam revealed loss of sensation in the lateral foot and tibia. The deep tendon reflexes were diminished in the left ankle. Straight leg raise was reported to be positive on the left. Flexion was to 80 degrees with extension and lateral bending to 10 degrees. The claimant was assessed with lumbar disc protrusion. The claimant was recommended for electrodiagnostic studies. The claimant was prescribed Mobic and Flexeril. The claimant saw Dr. on 04/17/12 with complaints of numbness of the left lower extremity. The note states the claimant had continued pain complaints despite four months of medications and physical therapy. Physical exam revealed loss of sensation in the lateral calf and foot. The reflexes were limited at the left ankle. Straight leg raise was reported to be positive on the left. Flexion was to 80 degrees with extension and lateral bending to 10 degrees. The claimant was assessed with lumbar disc protrusion. The claimant was prescribed Duexis and Flexeril. The claimant was recommended for left L4-5 and L5-S1 transforaminal epidural steroid injection.

The request for left L4-5 and L5-S1 transforaminal epidural steroid injection was denied by utilization review on 04/25/12 due to lack of a comprehensive neurologic examination documenting the claimant's current functional status, as well as no clear rationale for the necessity of the request. Additionally, the claimant's initial response to conservative treatment was not objectively documented. An appeal letter dated 05/01/12 states the claimant was performing her regular duty work with the assistance from coworkers for heavy lifting. The claimant required the epidural steroid injection to alleviate her pain complaints. The request for left L4-5 and L5-S1 transforaminal epidural steroid injection was denied by utilization review on 05/07/12 due to a lack of documentation of exhaustion or failure of conservative treatment, to include medication, activity modification, and physical therapy. Additionally, there was no indication that the procedure would be performed in conjunction with other rehabilitative efforts.

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

The clinical documentation provided for review documents that the claimant underwent an initial 3 sessions of physical therapy with a recommendation to continue physical therapy for an additional 6 sessions. The clinical documentation does not provide any indications that

these 6 sessions of additional physical therapy were completed and failed to improve the claimant's functional status. Current evidence based guidelines recommend that patients exhaust a reasonable amount of conservative treatment with no documented evidence of functional improvement before considering epidural steroid injections. As the claimant was recommended for additional physical therapy and there is no documentation on that this was completed, the requested epidural steroid injections at L4-L5 and L5-S1 are not medically necessary per guidelines and the prior denials are 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

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)