

SENT VIA EMAIL OR FAX ON
May/25/2012

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 OF REVIEW:
May/25/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
L5/S1 Intralaminar Lumbar ESI w/IV sedation, contrast, and Fluoroscopy

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
PM&R and Pain Medicine

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
Cover sheet and working documents
MRI lumbar spine dated 07/19/10
Pain management follow-up visit dated 02/23/12
Pre-authorization request dated 02/27/12
Pre-authorization determination dated 03/01/12
Pre-authorization determination dated 04/03/12

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. MRI of the lumbar spine dated 07/19/2010 revealed L5-S1 moderate disc desiccation and loss of vertical disc height; 2.5 mm AP dimension broad based disc bulge or disc herniation; abutment of both S1 nerve roots in the lateral recess without displacement; no significant foraminal stenosis; facet joint tropism and mild bilateral facet joint arthrosis. Follow up note dated 02/23/12 indicates that the patient rates her low back pain at a 5. On physical examination there is tenderness to

palpation at L2, L3, L4 and L5 and facet joint tenderness at L4-5 and L5-S1 bilaterally. Straight leg raising is positive bilaterally for numbness and tingling along the posterior aspect of the thigh. She reported diminished sensation to pinwheel on the left L4, L5 and S1 dermatomes compared to the right. Motor strength is symmetric at 5/5. Deep tendon reflexes are 2+ at the knees and 1+ at the ankles.

Initial request for L5-S1 intralaminar lumbar epidural steroid injection was non-certified on 03/01/12 noting that Official Disability Guidelines indicate that the criteria for the use of epidural steroid injections are "radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. Injections should be performed using fluoroscopy and injection of contrast for guidance. No more than one interlaminar level should be injected at one session". The patient was noted to have back pain that was unrelieved with medications and had a previous epidural steroid injection which gave her significant relief, but documentation is non-specific as to how much relief was obtained. The patient stated she had diminished sensation to pinwheel on the left L4, L5 and S1 dermatomes and motor strength was symmetric and 5/5 in tested muscle groups. The patient denied radicular symptoms returning and noted sustained improvement in her low back pain. The denial was upheld on appeal dated 04/03/12 noting that the patient was noted to have had previous epidural steroid injection with 70% relief of radicular component and 50-60% relief of low back pain. According to the clinical documentation provided, there is lack of evidence that the patient has been treated conservatively, given that there is a lack of physical therapy notes submitted for review. Furthermore, there is lack of evidence as to when the last is was performed and at what level the epidural steroid injections were performed, given that there was a lack of procedure notes submitted for review.

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

Based on the clinical information provided, the request for L5-S1 intralaminar lumbar epidural steroid injection with IV sedation, contrast and fluoroscopy is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There are no serial physical therapy progress notes submitted for review. The patient reportedly underwent previous epidural steroid injection; however, there are no procedure reports submitted for review documenting the dates and levels of the procedure(s). The patient's objective, functional response to previous epidural steroid injection is not provided to establish efficacy of treatment and support another lumbar epidural steroid injection. There is no clear rationale provided to support IV sedation.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES