

SENT VIA EMAIL OR FAX ON
May/29/2012

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/29/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Left Transforaminal Epidural Steroid Injection at the L5/S1 Level under Fluoroscopy with Intravenous Sedation

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

Cover sheet and working documents

Texas worker's compensation work status reports

Initial evaluation and progress notes Dr. dated 11/14/11-03/22/12

Clinic note DO dated 02/29/12

Utilization review determination dated 03/13/12

Utilization review determination dated 04/05/12

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. The earliest clinical record submitted for review is dated 11/14/11. This evaluation states that the patient sustained an exacerbation of a low back injury on xx/xx/xx. Diagnosis is bilateral lumbar sprain. The patient subsequently underwent a course of physical therapy. Follow up note dated 03/22/12 indicates that overall the symptoms have remained the same. Pain level has remained the

same (3). On physical examination there is full range of motion of the lumbar spine. Deep tendon reflexes are normal. Sensation is normal. Muscle strength is normal. Sitting straight leg raising is negative bilaterally. Supine straight leg raising is negative bilaterally. MRI of the lumbar spine dated 12/20/11 reportedly revealed spondylosis at L5-S1 with shallow left paracentral disc protrusion. The disc abuts the left S1 nerve root sleeve but does not displace or compress the left S1 nerve root.

Initial request for left transforaminal epidural steroid injection at L5-S1 was non-certified on 03/13/12 noting that the physical examination did not document weakness in a myotomal pattern or decreased sensation in a dermatomal pattern that would support the diagnosis of radiculopathy for which ESIs are indicated. There was no frank nerve compression documented on the MRI corroborate the findings of radiculopathy. The denial was upheld on appeal dated 04/05/12 noting that there was still no objective documentation of presence of radiculopathy aside from the positive straight leg raise test. There were no abnormalities with sensation, muscle and DTRs stated. The patient has had 6 PT visits that provided improvement.

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 1 left transforaminal epidural steroid injection at the L5-S1 level under fluoroscopy with intravenous sedation is not recommended as medically necessary, and the two previous denials are upheld. The patient's physical examination fails to establish the presence of active lumbar radiculopathy as required by the Official Disability Guidelines. The most recent physical examination dated 03/22/12 reports that on physical examination there is full range of motion of the lumbar spine. Deep tendon reflexes are normal. Sensation is normal. Muscle strength is normal. Sitting straight leg raising is negative bilaterally. Supine straight leg raising is negative bilaterally. The patient underwent MRI of the lumbar spine on 12/20/11; however, this report was not submitted for review. The submitted records also fail to establish that the patient has been unresponsive to conservative treatment. Given the current clinical data, the requested epidural steroid injection is not indicated 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)