

SENT VIA EMAIL OR FAX ON
Apr/30/2012

True Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Apr/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
OP LESI L5/S1, Epidurogram

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Cover sheet and working documents

MRI lumbar spine without contrast dated 09/29/11

Physical therapy initial visit and progress notes dated 10/26/11-01/30/12

Preauthorization inquiry for functional capacity evaluation undated

Texas worker's compensation work status report dated 02/22/12

Office notes Dr. dated 02/27/12-03/21/12

Notification of adverse determination dated 03/06/12

Patient health history updates 03/12/12, 03/26/12, and 04/16/12

Preauthorization request dated 03/15/12

Radiographic report dated 03/15/12 x-rays of lumbosacral spine, and AP pelvis

Acknowledgement of reconsideration request dated 03/20/12

Radiographic report lumbosacral spine and AP view pelvis dated 03/21/12

Notification of reconsideration determination dated 03/26/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xx. Records indicate he was operating a forklift which jerked him up and down with sudden onset of low back pain and right worse than left leg pain. MRI of the lumbar spine on 09/30/11 revealed disc degeneration and broad based 4mm central/right paracentral disc protrusion at L5-S1—may contact the proximal S1 nerve root—without neural impingement, canal stenosis or foraminal encroachment; otherwise unremarkable MRI of the lumbar spine. Examination of the lumbar spine on 02/27/12 reported straight leg raise test was negative bilaterally. Foraminal compression test was negative bilaterally. Femoral nerve stretch test was negative bilaterally. Motor examination showed excellent strength. There was no evidence of atrophy. There was no evidence of dermatomal sensory deficits. Reflexes were 1+ at the bilateral knees and ankles. There was no evidence of pathological reflexes. The claimant was recommended to undergo lumbar epidural steroid injection with epidurogram.

Per notice of adverse notification of adverse determination dated 03/06/12, a request for OP LESI L5-S1, epidurogram was non-certified as medically necessary. It was noted that per latest medical report dated 02/22/12 the claimant presented with low back pain. Physical examination showed negative bilateral straight leg raise test, excellent motor strength, no dermatomal sensory deficits and diminished but symmetric deep tendon reflexes. The objective findings in this claimant do not suggest radiculopathy. Based on MRI and objective findings it was also noted the MRI and objective findings do not corroborate. It was noted that the claimant's pain is reduced with medications which does not indicate failure of optimized pharmacotherapy. Hence medical necessity of lumbar epidural steroid injection is not established at this point.

Per notification of reconsideration determination dated 03/26/12, an appeal request for OP LESI L5-S1, epidurogram was again non-certified. It was noted that the request was previously non-certified due to lack of objective findings to suggest radiculopathy. The findings on the MRI and overall objective findings did not fully corroborate each other. It was noted that the claimant's pain was reduced with medications which did not indicate failure of an optimized pharmacotherapy. Current request contains medical report dated 03/12/12 with objective findings of positive straight leg raise test at 60 degrees on the right with normal strength and sensation on both lower extremities. However, an isolated finding of positive straight leg raise test without motor or sensory deficits does not in itself represent guideline associated objective evidence of radiculopathy. The MRI did not show evidence of frank nerve impingement. The other aforementioned issues were not addressed in this appeal request and therefore the previous non-certification is upheld.

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

The clinical data provided does not establish medical necessity for the requested outpatient lumbar epidural steroid injection L5-S1, epidurogram. The claimant is noted to have sustained an injury to the low back on xx/xx/xx. He has subjective complaints of low back pain with right worse than left leg pain. An MRI of the lumbar spine revealed degenerative changes with a 4mm broad based central/right paracentral disc protrusion at L5-S1 which may contact the proximal right S1 nerve root without displacement or impingement. There is no canal stenosis or foraminal encroachment. Examination on 02/27/12 reported excellent motor strength, no evidence of dermatomal sensory deficits, and symmetric reflexes at the knees and ankles. Straight leg raise was negative bilaterally. On follow-up examination dated 03/15/12 examination was unchanged except straight leg raise was reported as positive at 60 degrees on the right. However there was no indication if this was positive for low back pain only or for pain radiating below the level of the knee. Official Disability Guidelines provide that there should be documentation of radiculopathy with objective

findings on examination present, and radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. Based on the clinical data provided, medical necessity is not established for L5-S1 lumbar epidural steroid injection and previous 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)