

SENT VIA EMAIL OR FAX ON
Apr/20/2012

Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (817) 549-0311
Email: rm@independentresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Apr/20/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient lumbar epidural steroid injection (ESI) related to L4/5

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Orthopedic spines surgeon, practicing neurosurgeon

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

Notice of utilization review findings 03/30/12
Notice of utilization review findings 04/06/12
Neurosurgical consultation report M.D. 03/23/12
MRI lumbar spine 02/28/12
Progress note M.D. 03/13/12 and 02/29/12
Preauthorization request form 03/27/12
Preauthorization request form / reconsideration 04/02/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who was injured secondary to motor vehicle accident on xx/xx/xx. He complains of low back pain on left side and left leg pain. MRI of lumbar spine performed 02/28/12 revealed spondylosis and disc osteophyte complex at L4-5 with superimposed small

left paracentral disc herniation. There is mild left lateral recess stenosis and mild to moderate bilateral neural foraminal narrowing. The remainder of examination was unremarkable. Physical examination performed on 03/23/12 reported the claimant to be 6 feet tall and 158 lbs. Motor examination reported no pronator drift. Upper extremity strength was 5/5 on right and 4+/5 on left. Exam was somewhat limited by pain. Deep tendon reflexes were 2+ and symmetric. Toes were downgoing bilaterally and there is no clonus. There was altered sensation in left lower extremity. Gait was slow and antalgic, but non-ataxic. Straight leg raise was positive on left. Lumbar spine range of motion was limited to flexion/extension, lateral bending and rotation. The claimant was recommended to undergo lumbar epidural steroid injection as part of his ongoing conservative management of pain.

A notice of utilization review findings dated 03/30/12 recommended non-certification of outpatient lumbar epidural steroid injection related to L4-5. The reviewer noted the claimant sustained low back injury approximately 5 weeks ago in motor vehicle accident. Lumbar MRI is interpreted as consistent with spondylosis and disc / osteophyte complex at L4-5 with superimposed small left paracentral disc herniation. There is mild left lateral recess stenosis and mild to moderate bilateral foraminal narrowing noted. No electrodiagnostic studies were documented. No previous treatment was documented. The 03/23/12 provider note documented complaints of left sided low back pain and left leg pain. The claimant reported pain on ambulation and partial stress incontinence. On examination the claimant was noted to be in mild distress. Left upper extremity weakness was noted. Alteration in left lower extremity sensation was noted. Gait was slow and antalgic. Left straight leg raise was noted to be positive. Lumbar range of motion was limited. There is no details neurologic examination of lower extremity documented. It was noted objective evidence of radiculopathy such as focal lower extremity weakness, loss of sensation to specific dermatome, changes in deep tendon reflexes or positive EMG studies are not documented. In addition, previous course of conservative treatment is not documented. Therefore, non-authorization is recommended.

A notice of utilization review findings dated 04/06/12 again recommended non-authorization of outpatient lumbar epidural steroid injection related to L4-5. The original decision was to be upheld. Documentation reviewed indicated the claimant was injured in motor vehicle accident. He was seen in ER and discharged same day. The claimant was noted to have conservative treatment, but there were no details indicating what type of management was received or what results were. MRI performed 02/28/12 showed small paracentral bulge at L4-5, degenerative disc disease at multiple levels, and spondylosis and foraminal narrowing. There was no comprehensive evaluation of symptomatology. There is no detailed neurological examination. It was noted the claimant had severe pain upon palpation of low back, but no neurologic abnormalities were noted. Official Disability Guidelines recommendations indicate there must be documentation of radiculopathy on physical examination or electrodiagnostic studies (EDS) which is not documented in this case.

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

Based on the clinical information provided, the proposed outpatient lumbar epidural steroid injection (ESI) related to L4-5 is not supported as medically necessary. The claimant was involved in motor vehicle accident on xx/xx/xx and complained of left low back pain radiating to left lower extremity. MRI of lumbar spine revealed mild spinal stenosis and disc osteophyte complex at L4-5 with superimposed small left paracentral disc herniation which mildly narrows the left lateral recess. There was mild to moderate right sided foraminal narrowing and mild to moderate left sided foraminal narrowing as well. On examination there was noted altered sensation of left lower extremity, but no specific dermatomal distribution was identified. There was no evidence of motor deficit in lower extremities. Deep tendon reflexes were 2+ and symmetric throughout. There is no documentation of nature and extent of conservative treatment completed prior to pursuing epidural steroid injections. Official Disability Guidelines provide criteria for use of epidural steroid injections includes

requirement that radiculopathy must be documented with objective findings on examination present, and radiculopathy must be corroborated by imaging study and/or electrodiagnostic testing. There also should be evidence that the claimant initially was unresponsive to conservative treatment. Given the current clinical data, medical necessity is not established for outpatient lumbar epidural steroid injection at L4-5. Previous denials were correctly determined and are upheld on IRO.

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)