

True Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Nov/13/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right caudal ESI

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

Anesthesiology/Pain Management

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO dated 10/23/12
Receipt of request for IRO dated 10/23/12
Utilization review determination dated 09/20/12
Utilization review determination dated 09/28/12
Clinical note dated 05/30/12
Clinical note dated 09/17/12
Letter of appeal dated 10/23/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who has a date of injury of xx/xx/xx. She is reported to have had multiple surgeries. It is reported that on the date of injury she was attempting to perform an EKG on a patient and was transferring the patient when they fell backwards, knocking her across a table and hyperextending her back. She has had a 360-degree 2-level fusion with later removal of hardware. She is reported to have undergone spinal cord stimulator implantation which later required removal. She is reported to have low back pain with radiation to the lower extremities. She is noted to have a history of C5-7 fusion. She is noted to have comorbid urinary stress incontinence. Her medication profile has included Norco 10-325mg, Soma 350mg, Zantac 300mg daily, and Celebrex. On physical examination she is noted to be 5'5" tall and weighs 264 lbs. She has limited range of motion on all planes. Sensation is decreased globally throughout the lower extremities. Reflexes are trace and

symmetric at the patella and Achilles. Straight leg raise results in low back pain with radiation into the feet bilaterally. Motor strength is globally 5-/5 except for 4+/5 on right ankle dorsal flexion and 5/5 on lateral knee extension. Records indicate that the claimant was continued on oral medication. She was recommended to undergo a series of lumbar epidural steroid injections. The next available clinical record is dated 09/17/12. She is reported to have pain levels of 10/10 on the VAS scale with right lower extremity burning and aching. Medications are not helping. Her current medication profile includes Norco 10-325mg, Soma QID, Celebrex 200mg QD, and Gabapentin 300mg TID. She is noted to have decreased lumbar range of motion, positive straight leg raise on the right, and an antalgic gait. She subsequently was recommended to undergo caudal epidural steroid injection with possible catheter epidural lysis if the epidural steroid injection is not effective.

The record contains a letter of appeal from the claimant dated 10/23/12 which notes that she has had significant functional loss. She is unable to drive a motor vehicle as she feels she is unable to control her right lower extremity. She is noted to have an antalgic gait and is unable to bear weight on the right leg.

The initial review was denied on 09/20/12. recommended an adverse determination noting that the since the patient met ODG criteria for spinal cord stimulation, she would not meet the criteria for lumbar epidural steroid injections. He notes that an epidural steroid injection and spinal cord stimulator are mutually exclusive and as the patient met the criteria for spinal cord stimulator and had one implanted (and later removed), she would not meet ODG criteria for additional lumbar epidural steroid injections.

The appeal request was performed on 09/28/12. non-certified the request noting that there was insufficient clinical information provided. He notes that there is no comprehensive assessment of treatment completed to date or the patient's response to prior treatment. He notes that there were no imaging studies electrodiagnostic results provided to support the diagnosis of radiculopathy. He notes that as per the previous reviewer the claimant met criteria for spinal cord stimulator and would not meet the criteria for LESIs.

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

The request for right caudal epidural steroid injection is recommended as medically necessary and the prior utilization review determinations are upheld. The submitted clinical records while limited clearly indicate that the claimant has a failed back surgery syndrome with residual radiculopathy. While it is noted that the claimant has had a spinal cord stimulator in the past this device has been explanted and therefore there is no coverage for her lower extremity radicular symptoms subsequently the claimant is on multiple medications to include narcotic analgesics and neuromodulators without substantive benefit. The performance of a caudal epidural steroid injection in the presence of an active lumbar radiculopathy would be medically necessary under the Official Disability Guidelines and is therefore recommended.

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