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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Sep/25/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left L5/S1 Transforaminal Epidural Steroid Injection with Selective Nerve Root Block

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

Orthopedic spine surgery, 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)

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 09/11/12
Utilization review determination 08/10/12
Utilization review determination 09/07/12
MRI lumbar spine 12/12/11
Clinical records 02/20/12-07/18/12
Chronic pain management progress note 08/29/12
Request for 10 additional sessions of chronic pain management 08/29/12
Clinical note 03/19/12
Notice of IRO decision 06/12/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who is reported to have sustained work related injuries to his low back on xx/xx/xx. It is reported that he sustained an injury to his low back. the first available clinical record is an MRI of the lumbar spine which notes small broad based disc herniations at L2-3, L3-4, L4-5 and L5-S1. At L2-3 L3-4 and L4-5 there is mild bilateral and L5-S1 moderate bilateral foraminal narrowing at L5-S1 there's a grade 1 retrolisthesis

On 02/20/12, The claimant was seen. He is reported to have low back pain with radiation into the left foot. Treatment to date has consisted of massage, use of TENS and activity modification. He has comorbid diabetes and is treated with oral medications. On physical examination he is noted to have painful cervical range of motion in all planes with negative

provocative testing, upper extremity motor strength is graded as 5/5 with reflexes of 2/4 and sensation is intact. On examination the low back, the claimant is noted to have 5/5 strength, absent posterior tibialis reflexes bilaterally and intact sensation. Radiographs of the pelvis have shown mild degenerative joint disease of the left hip. Radiographs of the lumbar spine note decreased disc space at L5-S1. Radiographs of the left shoulder indicate post-operative changes. The claimant was referred for physical therapy and recommended to undergo MRI. He underwent a left subacromial injection at this visit.

The record includes an MRI of the cervical spine dated 03/19/12 this study notes an anterior cervical discectomy and fusion with anterior compression plate C3-4 and C5-6 with interbody fusion grafting seen at 6-7. There is reported to be impingement on the cord due to hypertrophic change at C5-6 but no abnormal cord signal enhancement

The claimant was seen in follow up on 04/02/12 claimant continues to have left shoulder pain neck pain with radiation into the trapezius and shoulders. There is tenderness over the bicipital tendon as well as the greater tuberosity with positive impingement sign, range of motion of the neck is painful, left biceps is graded as 4/5, triceps reflexes are 1/2. Upper extremity neurological examination is reported to be normal. The bilateral lower extremities are reported to be neurologically intact except for decreased sensation in the left lateral foot. Achilles reflexes are 1/2 and symmetric. Relafen was provided and he was recommended to undergo cervical and lumbar epidural steroid injections

The claimant was seen in follow up on 05/16/12. His symptoms are unchanged pain level is reported to be 8/10. The claimant has been attending physical therapy without much improvement. It is reported that the request for epidural steroid injection was denied.

The record contains an IRO determination dated 06/12/12 the IRO overturned the previous denials opining that there is evidence of a lumbar radiculopathy

On 06/04/12, the claimant was seen in follow up. There is a reported denial for the cervical epidural steroid injection. The claimant was seen in follow up on 07/18/12, it is reported that he has undergone a left side L5-S1 epidural steroid injection on 07/05/12. The claimant reports having complete relief of the lumbar pressure as well as 100% relief of the sharp lower extremity left leg radicular pain for a period of five days afterwards. The claimant's symptoms began to return. It is noted that the claimant has not had cervical epidural steroid injection approved. On physical examination, he is noted to have no more tenderness in the paraspinal muscles, minimal hyperesthesia along the left posterior thigh and the left hip flexor fatigue, there is weakness of the left EHL and tibialis anterior and a diminished Achilles left Achilles reflex. It is reported that dynamic imaging demonstrates collapse of L5-S1 with a disc vacuum phenomenon. There is a grade 1 L5-S1 spondylolisthesis which shoots from 2-5mm between flexion and extension. The claimant is recommended to undergo a second left sided L5-S1 transforaminal epidural steroid injection with selective nerve root block.

The initial review was performed on 08/11/12. opines that the claimant does not meet Official Disability Guidelines criteria. He notes that the claimant is status post L5-S1 epidural steroid injection with complete relief of 100% for five days with subsequent return of symptoms. subsequently notes that during the therapeutic phase after the initial block/blocks are given and found to and must be found to produce pain relief of at least 50-70% for at least six to eight weeks additional blocks may be supported.

The subsequent appeal request was reviewed on 09/07/12. non-certified the request noting that the patient has an underlying spondylolisthesis. He reports that there was no MRI of the lumbar spine forwarded. He indicates that the patient only received a five day benefit from recent epidural steroid injection and therefore the necessity of a repeat epidural steroid injection is unable to be confirmed by the records as long term benefit would be needed.

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

The request for left L5-S1 transforaminal epidural steroid injection with selective nerve root

block is recommended as medically necessary and the prior utilization review determinations are overturned. The submitted clinical records indicate that the claimant has low back pain with radiation to the left lower extremity in L5 distribution corroborated by both physical examination and MRI. The claimant's undergone an LESI of the on the left at L5-S1 with 100% relief for a period of five days. This response would be considered diagnostic and confirm the presence of a left L5-S1 radiculopathy. Therefore a second epidural steroid injection is clinically indicated as the claimant remains symptomatic. This second injection would be evaluated as a therapeutic injection and would require 50-70% pain relief for a period of six to eight weeks to justify additional blocks after epidural steroid injection number two. Based upon the submitted clinical records there is ample data to establish that the claimant would potentially have more prolonged benefit and meet criteria per the Official Disability Guidelines.

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)