

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Nov/26/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient right L4/L5 transforaminal epidural steroid injection (ESI)

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

Board Certified Neurosurgery

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

Utilization review determination dated 10/28/13, 09/25/13

Follow up note dated 09/23/13, 07/18/13, 07/01/13, 03/07/13, 01/10/13, 09/19/13, 10/10/13

MRI lumbar spine dated 10/17/13

Radiographic report dated 12/21/10, 06/05/09

Chart note dated 07/24/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient slipped and fell on a wet spot. Per note dated 01/10/13, a right selective nerve root block on 12/15/11 gave her 100% relief of her buttocks, leg and thigh pain for at least one week. It still continues to give her approximately 50% relief. She has a history of right hip replacement and is noted to be status post L5-S1 PLIF in 2001. Per note dated 07/01/13, the patient has undergone prior epidural steroid injections which have helped her pain significantly. Note dated 07/24/13 indicates that lumbosacral spine x-rays show the patient has a solid L5-S1 fusion. Note dated 09/19/13 indicates that the patient underwent right L4-5 transforaminal epidural steroid injection on 12/14/11 which provided at least 50% pain relief for more than 6 weeks. Physical examination on 10/10/13 indicates motor strength is 5/5 throughout with the exception of 4+/5 right quadriceps. Sensation is decreased in the right quadriceps. Deep tendon reflexes are 2+ throughout with the exception of 1+/4 right patellar reflex. MRI of the lumbar spine dated 10/17/13 revealed at L4-5 there is minimal spondylosis, 1-2 mm bulge greater on the left with moderate facet disease, and mild left neural foraminal narrowing.

Initial request for right L4-5 transforaminal epidural steroid injection was non-certified on 09/25/13 noting that radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. No MRI or electrodiagnostic testing results were provided to determine the medical necessity of the request. The denial was upheld on appeal dated 10/28/13 noting that ODG requires corroboration of radiculopathy with findings on MRI. ODG may be met if the pending MRI correlates with the physical exam. But as of this point, there are no imaging studies to corroborate the radiculopathy.

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

The patient slipped and fell on xx/xx/xx. There is no indication that the patient has undergone any recent active treatment. The patient has reportedly undergone multiple prior epidural steroid injections; however, there is no information provided regarding prior injections other than selective nerve root block on 12/15/11. The submitted lumbar MRI dated 10/17/13 fails to document any significant neurocompressive pathology, noting only mild left neural foraminal narrowing at the requested level. As such, it is the opinion of the reviewer that the request for outpatient right L4-5 transforaminal epidural steroid injection is not recommended 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)