

True Resolutions Inc.

An Independent Review Organization
500 E. 4th St., PMB 352
Austin, TX 78701
Phone: (214) 717-4260
Fax: (214) 276-1904
Email: rm@trueresolutionsinc.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Dec/10/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Epidural Steroid Injection at Bilateral L3/4, L4/5, L5/S1

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

Board Certified Anesthesiologist
Board Certified Pain Medicine

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:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 10/22/13, 11/12/13

Follow up note dated 10/07/13, 11/01/13, 09/11/13, 08/21/13, 07/24/13, 06/12/13, 05/03/13, 08/16/13, 09/04/13, 08/07/13

Operative report dated 03/26/13

Neurodiagnostic testing dated 01/18/13

MRI lumbar spine dated 10/04/12

MRI thoracic spine dated 08/22/13, 10/04/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. MRI of the lumbar spine dated 10/04/12 revealed at L3-4 normal hydration and no focal disc herniation. At L4-5 there is right paracentral and posterolateral disc protrusion with annuls tear measuring 3.13 mm with

right neural canal narrowing. At L5-S1 there is no focal herniation. There is no evidence of significant spinal stenosis or spondylolisthesis. Neurodiagnostic testing dated 01/18/13 revealed electrodiagnostic evidence suggestive of lumbosacral radiculopathy affecting the bilateral L5 and S1 nerve roots. The patient subsequently underwent full laminectomy of L4, exiting nerve root foraminotomy left sided L4-5 level, and right sided L4-5 discectomy on 03/26/13. Per note dated 07/24/13, the patient's low back pain has slightly improved with postoperative physical therapy. She continues to have low back pain which radiates to the bilateral legs and feet. Per note dated 08/16/13, the patient reports minimal relief of pain after surgery. Follow up note dated 10/07/13 indicates that medications include ibuprofen and Mobic. On physical examination strength is 4/5 knee flexion, knee extension, toe dorsiflexion on the left. Deep tendon reflexes are 0 bilateral ankles and left patella. Kemp's test is positive over lower lumbar facet joints bilaterally. Note dated 11/01/13 indicates that sensation is diminished in the left leg and left foot. Deep tendon reflexes are noted to be 2 throughout.

Initial request for lumbar epidural steroid injection at bilateral L3-4, L4-5 and L5-S1 was non-certified on 10/22/13 noting that there are three lumbar levels being requested for the epidural steroid injection which is not in accordance with the guideline criteria as only up to two levels are supported. There was also no documentation of an objective lumbar radiculopathy occurring at a specific level based on the physical examination findings and correlated with the workup done to support the need for the epidural steroid injection as well. The denial was upheld on appeal dated 11/12/13 noting that a three level root block is not supported by ODG. The patient has only left sided findings so there is no support for a right sided TFE. MRI showed no pathology at L3-4 or L5-S1 so there is no support for an injection here.

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

The patient underwent lumbar surgery on 03/26/13. There are no postoperative imaging studies and/or electrodiagnostic results submitted for review. The request for a three level epidural steroid injection is not supported by the Official Disability Guidelines which note that no more than two nerve root levels should be injected using transforaminal blocks and no more than one interlaminar level should be injected at one session. As such, it is the opinion of the reviewer that the request for Lumbar epidural steroid injection at bilateral L3-4, L4-5, L5-S1 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

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)