

I-Resolutions Inc.

An Independent Review Organization
3616 Far West Blvd Ste 117-501
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/22/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: transforaminal ESI L4-L5, L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M. D. Board Certified Anesthesiology and 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. It is the opinion of the reviewer that the request for transforaminal epidural steroid injection L4-5, L5-S1 is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 01/15/13, 02/15/13
Handwritten office note dated 02/15/13, 01/28/13, 01/08/13, 11/16/12, 08/24/12, 06/01/12, 03/09/12, 12/19/11, 10/03/11, 01/29/08, 05/15/08, 08/05/08, 10/27/08, 01/20/09, 03/11/09, 06/03/09, 07/20/09, 08/31/09, 01/22/10, 04/07/10, 01/25/11
MRI lumbar spine dated 06/10/09
Office note dated 01/08/13, 11/16/12, 08/24/12, 06/01/12, 03/09/12, 01/28/13
Authorization request form dated 01/09/13
Letter dated 03/05/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xxxxx. On this date the patient sustained a lifting injury. The earliest record submitted for review is a handwritten note dated xxxxxx. The patient has undergone multiple injections. The patient reported improvement of over one year with the last set of injections. Note dated xxxxx indicates that the patient is 6 weeks status post right transforaminal epidural steroid injection at L4-5 and L5-S1 and reports 70% pain relief with increased activity level. Note dated 01/20/09 indicates that right TFESI at L4-5 and L5-S1 provided 80-90% pain relief for 3 months. MRI of the lumbar spine dated 06/10/09 revealed at L4-5 the disc is moderately narrowed with dehydration. A large right paracentral and inferiorly directed disc herniation probably compresses the right L5 nerve root as it enters its neural foramen. Facet degeneration contributes to at least moderate right foraminal encroachment. At L5-S1 the disc is moderately narrowed with dehydration. Broad annular bulging is contained within anterior extradural fat. Facet degeneration contributes to at least mild bilateral foraminal encroachment. Note dated 07/20/09 indicates right L4-5 TFESI provided 60% pain relief. Note dated 04/07/10 indicates that the patient is status post spinal cord stimulator implantation in March 2010. Office visit note dated 01/08/13 indicates that the patient is

having some problems with his spinal cord stimulator and presents for reprogramming. Otherwise, meds remain effective and allow him to be more active and improve ADLs. Current medications are listed as Norco, Flexeril, Gabapentin and Celebrex. Authorization request form dated 01/09/13 indicates that the patient's spinal cord stimulator charger is not working properly. Without effective stimulation, the patient's pain level has increased.

Initial request for transforaminal epidural steroid injection L4-5, L5-S1 was non-certified on 01/15/13 noting that although the patient reports symptoms due to failure of a spinal cord stimulator, there is no recent examination data to support epidural steroid injection. Guidelines generally require documented radiculopathy with objective findings on examination and require corroboration by imaging studies. There are no recent exam findings documented within the records reviewed. The denial was upheld on appeal dated 02/15/13 noting that the provider submitted a progress report from 01/28/13 which again does not document any objective clinical findings. As such, it remains that there are no current objective clinical findings to substantiate that the patient has active radiculopathy. According to the ODG guidelines, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing to warrant epidural steroid injection. Without evidence of radiculopathy, the medical necessity for TFESI at L4-5, L5-S1 cannot be established.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The submitted records include recent office visit notes dated 01/08/13 and 01/28/13; however, these records do not provide a current, detailed physical examination. The Official Disability Guidelines note that radiculopathy must be documented, and objective findings on examination need to be present. There is no current, detailed physical examination submitted for review to establish the presence of active lumbar radiculopathy. As such, it is the opinion of the reviewer that the request for transforaminal epidural steroid injection 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

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)