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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/09/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 1 lumbar epidural steroid injection at the L4-L5 under fluoroscopy, epidurography and epidural lysis

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery

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 1 lumbar epidural steroid injection at the L4-L5 under fluoroscopy, epidurography and epidural lysis is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 06/14/13, 07/15/13

Office note dated 01/17/13, 01/15/13, 01/11/13, 12/11/12

EMG/NCV dated 04/01/13

Work capacity evaluation dated 05/16/13

Behavioral evaluation report dated 05/16/13

Peer review dated 05/13/13, 01/10/13

Designated doctor report dated 03/04/13

Orthopedic report dated 07/03/13, 06/06/13

Radiographic report dated 12/11/12

MRI lumbar spine dated 01/24/13

Manual muscle strength exam dated 04/04/13

Subsequent medical report dated 03/12/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. On this date the patient fell and injured his lower back and bilateral hips. Peer review dated 01/10/13 indicates that the compensable injury is lumbar sprain; there is no evidence of thoracic strain with this injury. The patient underwent a course of physical therapy. MRI of the lumbar spine dated 01/24/13 revealed at L4-5 disc is mildly desiccated and reveals broad based posterior and right paracentral as well as foraminal herniation. It indents the thecal sac, both L4 and L5 nerve roots and causes mild narrowing of central canal and neural foramina bilaterally. The herniation measures approximately 5 mm in size. Designated doctor report dated 03/04/13 indicates that the patient reached maximum medical improvement on 01/18/13 after finishing his PT sessions. His symptoms were stable and not improving. He had no symptoms of radiculitis at this point. He has suffered a lumbar strain which should have resolved with conservative measures and physical therapy. The patient

was given 0% whole person impairment. EMG/NCV dated 04/01/13 revealed electrophysiologic evidence most consistent with an active radiculopathy process involving the left L4 nerve root level compared to a relatively inactive radiculopathy process at the left L5 nerve root level. Peer review dated 05/13/13 indicates that the patient was recommended to undergo left epidural steroid injection at L4-5 x 1. Orthopedic report dated 06/06/13 indicates that medications include amlodipine, Tramadol and ibuprofen. On physical examination gait is antalgic and compensated. Strength is rated as 5/5 in the lower extremities with the exception of 4/5 left knee extension and flexion. Deep tendon reflexes are 2/4. There is decreased sensation left L5. Straight leg raising causes back pain only on the right and posterior thigh pain on the left.

Initial request for 1 lumbar epidural steroid injection at the L4-5 under fluoroscopy, epidurography and epidural lysis was non-certified on 06/14/13 noting that the patient does have objective evidence of radicular pain and is noted to have remained symptomatic despite utilizing various forms of conservative treatment. However, it is further indicated in the guidelines that epidural neurolysis is not recommended due to the lack of sufficient literature evidence. Given that the planned epidural steroid injection involves the use of epidural lysis, the medical necessity of this request is not substantiated. The denial was upheld on appeal dated 07/15/13 noting that guidelines do not recommend an epidurolysis, and although the epidural steroid injection may be indicated, the request in its entirety is not supported.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient underwent MRI of the lumbar spine on 01/24/13 which revealed at L4-5 disc is mildly desiccated and reveals broad based posterior and right paracentral as well as foraminal herniation. It indents the thecal sac, both L4 and L5 nerve roots and causes mild narrowing of central canal and neural foramina bilaterally. The herniation measures approximately 5 mm in size. EMG/NCV dated 04/01/13 revealed electrophysiologic evidence most consistent with an active radiculopathy process involving the left L4 nerve root level compared to a relatively inactive radiculopathy process at the left L5 nerve root level. On physical examination gait is antalgic and compensated. Strength is rated as 5/5 in the lower extremities with the exception of 4/5 left knee extension and flexion. Deep tendon reflexes are 2/4. There is decreased sensation left L5. Straight leg raising causes back pain only on the right and posterior thigh pain on the left. Although it appears that a lumbar epidural steroid injection may be appropriate, the Official Disability Guidelines do not support epidural neurolysis due to the lack of sufficient literature evidence. As such, it is the opinion of the reviewer that the request for 1 lumbar epidural steroid injection at the L4-L5 under fluoroscopy, epidurography and epidural lysis 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)