

Applied Resolutions LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jun/21/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left LESI L3/4

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

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Peer to peer contact form 05/22/13
Operative report 03/18/10
Operative report 01/03/11
Operative report 06/30/11
Clinical records 01/17/12-01/23/13
MRI lumbar spine 09/13/12
Clinical record 03/13/13
Prior reviews 05/23/13 and 06/05/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx while lifting. The patient underwent multiple surgical procedures including revision of previous lumbar fusion at L4-5 and L5-S1 with lumbar fusion at L3-4 in 01/11. The patient underwent further revision of the lumbar fusion in 06/11. Post-operatively the patient was recommended for a DARS retraining MRI of the lumbar spine on 09/13/12 demonstrated prior fusion at L3-4 and L4-5 and L5-S1. Clumping of the lumbosacral nerve roots was present at L3-4 consistent with arachnoiditis. No significant neural foraminal or canal stenosis was noted at L4-5 or L5-S1. The patient was assessed with failed back surgery syndrome. Clinical record on 05/13/13 stated that the patient had persistent low back pain and leg pain. Physical examination demonstrated decreased strength on left hip flexion and knee extension. Reflexes were trace to absent to the left and hyperreflexic to the right. There was altered sensation in the lateral thigh and

calf. The patient was recommended for epidural steroid injection at L3-4 due to increasing radicular symptoms. The requested epidural steroid injection at L3-4 was denied by utilization review on 05/23/13 as conditions that would support epidural steroid injections were not discussed. The request was again denied by utilization review on 06/05/13 as there was no current detailed physical examination establishing the presence of an active lumbar radiculopathy that would support the requested procedure.

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

The patient has been followed for chronic low back pain stemming from multiple lumbar fusion procedures in 2011. Per the case management notes the patient attended 35 sessions of a chronic pain management program. As the patient has been treated with a tertiary level of chronic pain management, and the objective findings are not consistent with a clear diagnosis of lumbar radiculopathy, it is unclear from the clinical documentation submitted for review how the patient will reasonably respond to epidural steroid injections in regards to increased function and decreased pain. Current complaints are clearly secondary to failed back surgery syndrome and this diagnosis alone would not support the use of epidural steroid injections in this chronic pain case. As such it is the opinion of this reviewer that medical necessity is not established due to the insufficient objective evidence regarding lumbar radiculopathy and the extensive but failed chronic pain management for this patient to date. As such the prior denials are upheld.

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)