

True Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Oct/27/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar ESI, epidurography

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

MD, Board Certified PM&R

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. While working he strained his back. MRI of the lumbar spine dated 05/29/14 revealed a central L4-5 disc herniation/extrusion, ligamentum flavum hypertrophy. There is 50% spinal canal stenosis and foraminal narrowing. There is acute interspinous ligament strain identified at L3-4, L4-5 and L5-S1. EMG/NCV dated 08/09/14 revealed electrodiagnostic evidence suggestive of an acute/subacute right L4 radiculopathy. Orthopedic consultation dated 09/26/14 indicates that he has done physical therapy that helped a lot with the back pain, but not really with his leg pain. Medication is hydrocodone. On physical examination heel and toe walk are normal. Lumbar range of motion is extremely limited in flexion and extension. Motor strength is 5/5 throughout the bilateral lower extremities. Sensation is intact. Straight leg raising is markedly positive on the right. Deep tendon reflexes are 2/4 in the bilateral lower extremities.

Initial request for lumbar epidural steroid injection, epidurography was non-certified on 08/29/14 noting that the level/laterality was not specified in the request. There were no physical therapy notes provided for review that would indicate the amount of physical therapy visits the patient has completed to date or the patient's response to any previous conservative treatment. There were no focal neurological deficits on recent physical examination. There was no recent detailed physical examination of the lumbar spine provided for review that would indicate any decreased motor strength, increased reflex or sensory deficits. There was no indication that the patient is actively participating in a home exercise program. The denial was upheld on appeal dated 09/16/14 noting that there were no physical therapy notes submitted for review. There was no additional significant objective

clinical information provided for review that would support reversing the previous adverse determination.

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

The patient sustained injuries on xx/xx/xx and has completed a course of physical therapy. The request for lumbar epidural steroid injection is nonspecific and does not indicate the level, laterality or approach to be performed. The patient's physical examination fails to establish the presence of active lumbar radiculopathy as required by the Official Disability Guidelines with intact motor strength, reflexes and deep tendon reflexes in the lower extremities. As such, it is the opinion of the reviewer that the request for lumbar epidural steroid injection, epidurography 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)