

True Resolutions Inc.
An Independent Review Organization

Phone Number:
(512) 501-3856

2771 E Broad St. Suite 217 #172
Mansfield, TX 76063

Email: trueresolutions@irosolutions.com

Fax Number:
(512) 351-7842

Notice of Independent Review Decision

Case Number:

Date of Notice: 04/15/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Anesthesiology And Pain Management

Description of the service or services in dispute:

Lumbar Epidural Steroid Injection Left L4 L5 S1

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)

Patient Clinical History (Summary)

The patient is a female who reported injury on XX/XX/XX. The mechanism of injury was when she slipped on a strawberry, and fell to the ground. The patient was diagnosed with intervertebral disc displacement, and radiculopathy of the lumbosacral region. An MRI of the lumbar spine performed on XX/XX/XX revealed a 4.08 mm posterior central disc protrusion, with annulus tear, and mild thecal sac impingement at L4-5. There was a transitionally narrowed L5-S1 disc. Treatment to date includes exercise, massage, modified activities of daily living, medications, 16 sessions of physical therapy, and an epidural steroid injection. No recent physical exam was provided for review. The documents are mostly illegible. The most recent physical exam provided was performed on XX/XX/XX. The patient reported low back pain with radiation into the left leg greater than right leg. The pain was described as throbbing, shooting, sharp, cramping, aching, stabbing, tingling, numbness, and dull. The pain was constant. Exacerbating factors included standing, walking, sneezing, coughing, weather changes, lifting, lying down, and sitting. Relieving factors included resting. Physical exam findings included, myofascial spasms, kemp's test was positive, left straight leg positive at 30 degree elevation reproducing concordant ipsilateral axial lumbar, and neuropathic pain in the L4, L5, and S1 nerve root distribution. There was decrease in motor strength, L Quadriceps, L EHL, and L Gastroc soleus 4+/5. Deep tendon reflexes were, L patellar 1 of 4, and L Achilles trace. Sensation was decreased to light touch in the L4, L5, and S1 nerve root distribution. On XX/XX/XX, the physician reported the patient had failed to benefit from sessions of physical therapy. The patient experienced significant relief from a previous lumbar epidural steroid injection. By patient report during the exam, this was a right lumbar epidural steroid injection. By report, the patient had greater than 50% relief from constant pain for greater than 3 months, with functional improvement in her ability to perform activities of daily living, and greater than 50% reduction in her need for analgesic medications.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The Official Disability Guidelines recommended repeat injections should be based on continued objective

documented pain relief, decreased need for pain medications, and functional response. The previous request was denied based on the clinical documentation submitted for review did not note the level of the previous epidural steroid injection; there was also no documentation noting objective improvement from the previous injection noting decreased need for pain medications, functional improvement, and at least 50% to 70% pain relief for 6 to 8 weeks. Additional documentation was provided addressing these points. The patient reported significant relief from previous lumbar epidural steroid injection. The patient reported during the exam this was a right sided lumbar epidural steroid injection. The request is for left sided epidural steroid injection. Physical exam revealed symptoms of radiculopathy to include, pain with numbness and tingling radiating to the extremities, decreased motor strength, sensory loss, and reflex loss. The patient has failed conservative care to include 6 sessions of physical therapy. Given the patient's symptoms despite conservative care, the requested treatment is medically necessary. Therefore, the previous determination is overturned.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPH-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment Guidelines
- Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)