



Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 9/14/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for left L5 and S1 transforaminal epidural steroid injection, lumbar with Epidurogram.

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

Texas licensed Anesthesiologist.

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 or not medical necessity exists for each of the health care services in dispute.

The previously denied request for left L5 and S1 transforaminal epidural steroid injection, lumbar with Epidurogram.

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years

Gender: Female

Date of Injury: xx/xx/xx Mechanism of

Injury: Slip and fall Diagnosis:

Lumbar disc displacement

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

This xx year-old female had a date of injury of xx/xx/xx. The patient sustained a low back injury when she slipped and fell in a parking lot. Physical therapy was provided that was of no benefit. The patient was seen by Dr. on 5/9/09 and there was noted to be a positive straight leg raise (SLR) on the left. A subsequent MRI was ordered. The MRI performed on 5/15/09 was remarkable for an L5-S1 small annular tear. The patient was seen by Dr. on 7/23/09. There was no radicular pain. There was noted to be a positive left SLR on physical examination. Reflexes were symmetrical and the only other abnormality was a positive Kemp's test. There were no gross neurologic deficits noted. Based on these findings, there was a recommendation for a transforaminal ESI at L5 and S1. The Official Disability Guidelines support the use of ESI's when there is the presence of radiculopathy. This is defined as a dermatomal distribution of pain, along with an objective finding to support the cause of the radiculopathy, such as an MRI. An MRI was performed in this case, and there was noted to be an annular tear at L5-S1. Although not a neurocompressive lesion, the nucleus pulposus leaking from the tear can cause nerve root irritation and subsequent radiculopathy. Therefore, the request would be considered medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.
Official Disability Guidelines (ODG), Treatment Index, 7th Edition, (web), 2009, Low back – Epidural steroid injections (ESIs). “Recommended as a possible option of short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts.”

- 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).