MedHealth **R**eview, **I**nc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax 972-775-6056

Notice of Independent Review Decision

DATE OF REVIEW: 5/9/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an injection single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography or therapeutic substances).

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

The reviewer is a Medical Doctor who is board certified in Anesthesia and Pain Management. The reviewer has been practicing for greater than 10 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of an injection single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography or therapeutic substances).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with history of persistent low back pain following an industrial injury on xx/xx/xx, despite non-steroidal anti-inflammatory medications, muscle relaxants, oral steroids, and modification of activity. An MRI study performed on 2/14/11 revealed multilevel diffuse disc bulging with annular protrusion impinging on the thecal sac at L5-S1, central spinal stenosis from T11-S1, and facet hypertrophic changes from T11-S1. Physical examination has revealed a positive left straight leg raise, “good” heel to toe walking, and sensory deficit in the left L5-S1 dermatome. An office note from Pain Therapeutics dated 3/10/2011 indicates that physical therapy was performed and that the patient failed this treatment.

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

The medical record indicates the presence of symptoms (pain radiating down the leg), signs (positive straight leg raise test, sensory deficit), and appropriate objective testing modalities (MRI indicating intervertebral disc bulging with disc protrusion impinging upon the thecal sac at L5-S1) which support the diagnosis of lumbosacral radiculopathy. Furthermore, the record indicates the patient has failed conservative measures including NSAIDS, oral steroids, muscle relaxants, alteration in activity, and physical methods (the PT mentioned above). Based on the ODG guidelines the proposed epidural steroid injection is medically appropriate and does meet the criteria for medical necessity.

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

- ☐ ACOEM- AMERICAN 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)