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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/14/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar Epidural Steroid Injection/Fluoroscopy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Anesthesiology; Board Certified Pain Management

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] 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. The reviewer finds medical necessity is not established for the requested Lumbar Epidural Steroid Injection/Fluoroscopy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
MRI lumbar spine without contrast dated 10/17/11
X-ray report lumbar spine 4 views 11/15/11
Consultation and follow-up report dated 03/19/12 and 09/10/12
Electrodiagnostic testing dated 08/10/12
Report of medical evaluation dated 08/31/12
Utilization review determination dated 09/21/12
Utilization review determination dated 10/09/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who was injured on xx/xx/xx. The records indicate that she bent over and when she stood back up she had sharp pain to the left lower back into the gluteal area. She developed increasing numbness into the 2nd, 3rd, and 4th toes of the right foot with pain shooting down both legs. The claimant was treated conservatively with physical therapy and medications. MRI of the lumbar spine dated 10/17/11 revealed multi-level disc bulging/spondylosis without significant spinal stenosis or foraminal nerve root compression. X-rays of the lumbar spine on 11/15/11 reported moderate degenerative disc disease at L2-L5. Electrodiagnostic testing on 08/10/12 revealed possible lower limb peripheral polyneuropathy, but no evidence of lumbar radiculopathy, peroneal, lateral plantar or tibial neuropathies or myopathies. The claimant underwent a repeat designated doctor's evaluation on 08/31/12. Physical examination on that date revealed continued tenderness to palpation with decreased range of motion. The claimant was able to walk with a normal gait and stand on heels and toes. Reflexes were +2 at the patella and Achilles tendon. Muscle strength was 5/5 bilaterally and the claimant was able to rise from the treatment table with no apparent distress. Seated straight leg raising was negative with no spasms noted. It was

noted that the extent of injury/diagnosis is lumbar sprain with aggravation of degenerative disc disease. The claimant was seen in follow-up on 09/10/12. noted that the claimant had a positive EMG showing nerve root irritation. He also noted that the claimant continues to have back pain that radiates into both legs, worse on the right. On examination, the claimant was slow getting up from a seated position. There was tenderness to palpation on L3-5 with paresthesias into the foot.

She has some decreased sensation on the right compared to the left and on top of the foot. EMG reportedly showed right-sided L5 radiculopathy and bilateral L5 and S1 radiculitis. The claimant was recommended to undergo epidural steroid injection.

A pre-authorization request for lumbar epidural steroid injection/fluoroscopy was reviewed on 09/21/12, and adverse determination was rendered. It was noted that there was no disc herniation, high-grade foraminal stenosis or nerve root compression on lumbar MRI. There was no compression of any neurologic structure in support of the diagnosis of radiculopathy. Electrodiagnostic testing does not support a diagnosis of lumbar radiculopathy but may support a diagnosis of peripheral neuropathy. Diagnosis of lumbar radiculopathy is unsupported, and epidural steroid injection is not recommended in the absence of radiculopathy.

A reconsideration request for lumbar epidural steroid injection/fluoroscopy was reviewed on 10/19/12 and adverse determination was rendered. It was noted that the claimant has chronic low back and leg pain with paresthesias and numbness in the foot on exam. EMG NH/12 was negative for lumbar radiculopathy. MRI showed no significant disc herniation or foraminal/canal stenosis. Therefore, there is no objective imaging or nerve test that confirms the exam findings. Therefore, the request for epidural steroid injection is not supported by current evidence based guidelines.

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

The claimant sustained an injury to the low back on xx/xx/xx. She experienced left lower back pain with pain into the gluteal area and developed numbness into the 2nd, 3rd, and 4th toes of the right foot with pain shooting down both legs. She was treated conservatively with physical therapy and medications but remained symptomatic. Imaging studies revealed no evidence of significant spinal stenosis or foraminal nerve root compression. Electrodiagnostic testing on 08/10/12 was negative for lumbar radiculopathy but showed findings of possible lower limb peripheral polyneuropathy. Examination on 09/10/12 reported tenderness to palpation at L3-L5 with paresthesias into the foot and some decreased sensation on the right compared to the left and top of the foot. ODG provides that radiculopathy must be documented with objective findings on examination present and radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. The record presented reveals no objective evidence of nerve root compression on imaging studies, and electrodiagnostic testing was negative for lumbar radiculopathy. The reviewer finds medical necessity is not established for the requested Lumbar Epidural Steroid Injection/Fluoroscopy.

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

[X] 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

[ ] 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)