US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/25/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
62311 Lumbar Epidural Steroid Injection. Level(s) Not Identified and 77003 Fluoroscopic Guidance

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 62311 Lumbar Epidural Steroid Injection. Level(s) Not Identified and 77003 Fluoroscopic Guidance.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Employer's first report of injury or illness dated xx/xx/xx
Associate's statement dated xx/xx/xx
Authorization for release for medical records and reports xx/xx/xx
X-ray lumbar spine 3 views dated xx/xx/xx
Emergency physician record xx/xx/xx
Office visit notes Dr. dated 10/11/10-01/28/11
Bona Fide Job Offer Temporary Alternative Duty dated 10/16/10, 02/27/11, 03/11/11, 08/15/11, and 09/16/11
PT daily notes dated 10/19/10-01/12/11
MRI lumbar spine dated 01/18/11
Multiple progress notes and letters of medical necessity 1st Choice Treatment Clinic dated 03/07/11-09/12/12
Office visit notes Dr. dated 03/21/11-10/02/12
Neuromuscular electrical stimulator supply order dated 03/22/11
Initial interview for mental health treatment dated 03/24/11
Description of services dated 04/01/11
EMG/NCV studies dated 04/01/11
Individual psychotherapy progress notes dated 04/18/11-05/18/11

Peer review report dated 04/18/11 and addendum dated 04/27/11
Description of services dated 05/02/11
Physical performance evaluation dated 06/01/11
History and physical Dr. dated 06/28/11
IRO review dated 07/07/11
Description of services dated 08/04/11
Description of services dated 09/06/11
CT lumbar post myelogram dated 09/06/11
Lumbar myelogram 09/06/11
CT lumbar post myelogram dated 09/06/11
Description of services dated 10/06/11
Description of services dated 11/07/11
Description of services dated 12/07/11
Office visit notes Dr. dated 12/08/11-02/23/12
X-ray report lumbar spine 7 views dated 01/18/12
Daily activities work sheets for work hardening dated 01/23/12-02/14/12
Supply order dated 02/07/12
Description of services dated 03/09/12
Ultrasound of lumbar region dated 03/28/12
Description of services dated 04/09/12
Description of services dated 05/09/12
Description of services dated 06/11/12
Functional capacity evaluation dated 07/18/12
Utilization review determination dated 07/20/12
Description of services dated 08/13/12
Office visit note Dr. dated 08/15/12
Utilization review determination dated 08/21/12
Utilization review determination for a different request dated 08/22/12
Notice of independent review decision dated 08/29/12
Report of medical evaluation dated 10/02/12
Claim history report 10/09/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female whose date of injury is xx/xx/xx. Per employer's first report of injury or illness, the claimant got hurt. She complains of low back pain radiating to the right lower extremity. MRI of the lumbar spine dated 01/18/11 revealed diffuse disc bulge at L1-2 and L2-3 with mild canal stenosis at both levels and right foraminal stenosis at L2-3. At L3-4 there is disc desiccation with diffuse disc bulge, facet arthropathy with mild canal and bilateral foraminal stenosis. At L4-5 there is diffuse disc bulging with moderate canal and bilateral foraminal stenosis, moderate facet arthropathy. At L5-S1 there is left lateral disc protrusions, facet arthropathy, and no canal or foraminal stenosis. Electrodiagnostic testing performed 04/01/11 was noted to reveal evidence of L4 radiculopathy on the right and left. The claimant underwent extensive conservative care including physical therapy, chiropractic care and activity modification medications, and activity modification. The claimant also was treated with individual psychotherapy times six sessions. Claimant also participated in a work hardening program. Claimant was recommended to undergo lumbar laminectomy at L4-5 and L5-S1, but the proposed surgical procedure was determined as not medically necessary. A request for lumbar epidural steroid injection (levels not identified) was denied per utilization review dated 07/20/12. The reviewer noted that EMG/NCV on 04/01/11 was not done in accordance with Official Disability Guidelines recommendations and reported bilateral L4 radiculopathy. MRI of the lumbar spine on 01/18/11 revealed multilevel disc bulges with facet arthropathy, and varying degrees of canal and foraminal stenosis. There were no notes from the requesting provider, and the requester had not seen the claimant. The request was being submitted on basis of referral from the treating chiropractor. An appeal request for lumbar epidural steroid injection (levels not identified) was denied per utilization review dated 08/21/12 noting that review of physical examination did not document active signs of radiculopathy though the claimant was known to have low back pain radiating to the bilateral legs. EMG was considered positive for "bilateral L4-5 radiculopathy" (a highly unlikely finding) and there appears to be no structural evidence to support the diagnosis on advanced

imaging.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The claimant is noted to have sustained an injury to the low back due to heavy lifting. MRI of the lumbar spine revealed multilevel degenerative change with diffuse disc bulging. At L3-4 there is mild canal and bilateral foraminal stenosis. At L4-5 there was moderate canal and bilateral foraminal stenosis. At L5-S1 there was no canal or foraminal stenosis. There was no evidence of focal disc herniation with nerve root compression at any level. EMG was noted to show bilateral L4 radiculopathy, but this was a questionable finding. There was no documentation of active radicular findings on physical examination.

The evidence based guidelines have not been met. The reviewer finds medical necessity is not established for the requested 62311 Lumbar Epidural Steroid Injection. Level(s) Not Identified and 77003 Fluoroscopic Guidance.

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)