Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 11/19/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of an epidural steroid injection @ L3-4.

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 Physical Medicine and Rehabilitation.

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 agrees with the previous adverse determination regarding the prospective medical necessity of an epidural steroid injection @ L3-4.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed:

Progress Daily Notes – 9/18/13, 9/25/13

MRI lumbar spine w/o contrast – 5/8/13

Records reviewed:

Pre-authorization Report & Notification – 10/10/13, 10/14/13

Pre-authorization Report & Notification Draft – 10/18/13

Pre-authorization Request – 9/25/13
Follow-up Evaluations – 8/15/13, 9/19/13
Appeal – 10/7/13

Pre-authorization Request – 9/12/13

Referral Letter – 9/4/13
Re-Examination Report – 8/16/13

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:
According to the records, this worker was injured on xx/xx/xx while working in his usual occupation. The patient has been treated with chiropractic therapy and has been seen by pain management. He underwent a left L3-4 epidural steroid injection on July 18, 2013. According to the records, this reduced his pain and his need for pain medication. The pain management physician saw the injured worker on September 19, 2013 and stated specifically that the epidural steroid injection "he received back in July provided him with a fair amount of relief, but the effect was only temporary, as it did not last him more than a month."

A repeat epidural steroid injection has been recommended. The clinical record indicates that MRI studies performed on May 8, 2013 showed an L3-4 disk bulge with central disk herniation, moderate central canal stenosis, and severe stenosis of bilateral lateral recesses impinging on the L4 nerve roots bilaterally. The patient has been diagnosed with a left leg radiculopathy although the chart does not indicate any evidence of reflex asymmetry, sensory loss, atrophy of muscles, or isolated weakness.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
According to available medical records, this worker was injured in a work-related accident on xx/xx/xx. He did sustain an injury to his back. The extent of that injury is not clearly identified in the medical record. There was a question as to whether or not the patient had sustained a strain or sprain or had sustained an actual disk herniation with nerve root impingement resulting in radiculopathy. The injured worker did undergo a left epidural steroid injection at the L3-4 level on July 18.

This record clearly indicates that the injured worker did note improvement in pain, but the record also clearly indicates that the relief was only temporary and lasted only one month, not the 50% to 70% relief lasting at least six to eight weeks as recommended by the ODG Treatment Guidelines. This medical record does not

provide documentation that there is a medical necessity of a repeat epidural steroid injection at L3-4 as recommended by the ODG Treatment Guidelines. Therefore, the request is not 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 & 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)**