

# Applied Resolutions LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Oct/15/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar epidural steroid injection with fluoroscopy or CT guidance, single level

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

Neurosurgery

**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 medical necessity exists for each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
Clinical reports dated 04/16/08 – 05/28/08  
MRI of the cervical spine dated 02/23/13  
Physical therapy assessment dated 04/28/08  
Prior peer review reports dated 04/02/13 & 04/15/13  
Operative report dated 01/27/09  
Clinical reports dated 07/02/08 – 05/12/10  
MRI of the lumbar spine dated 05/08/08  
Radiographs of the lumbar spine dated 07/02/08  
Clinical report dated 01/30/13  
MRI of the lumbar spine dated 02/23/13  
Clinical report dated 03/25/13  
Clinical report dated 06/05/13  
Clinical report dated 06/19/13  
Electrodiagnostic studies dated 07/25/13  
Clinical report dated 07/26/13  
Clinical report dated 07/31/13  
Prior reviews dated 08/09/13 & 09/11/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who sustained an injury on xx/xx/xx when he was involved in a motor vehicle accident. The patient is status post anterior cervical discectomy and fusion at C6-7

performed in January of 2009. The patient has also been followed for complaints of low back pain radiating to the left lower extremity. MRI studies of the lumbar spine completed on 02/23/13 showed evidence of disc space narrowing at L2-3 with posterior disc bulging at L4-5 with facet hypertrophy contributing to mild canal and foraminal stenosis. At L5-S1, there was a grade 1 retrolisthesis of L5 on S1 with disc space narrowing noted. Disc bulging and facet hypertrophy narrowed the neuroforamina. There were recommendations for diagnostic and therapeutic L4-5 selective nerve root blocks on 03/25/13. EMG studies of the lower extremities completed on 07/26/13 showed evidence of a chronic inactive left L4 radiculopathy. The clinical report on 07/26/13 reported decreased sensation in the left inner thigh with a mildly positive straight leg raise to the left side. Follow up on 07/31/13 stated that the patient continued to have low back pain radiating to the lower extremities. There was a positive straight leg raise reported to the left on physical examination with depressed reflexes in the left upper extremity and patella. There was very minimal weakness reported at the left tibialis anterior. The patient was recommended for a left L4-5 selective nerve root block to address the patient's symptoms.

Epidural steroid injections were denied by utilization review on 08/09/13 as there were minimal findings for an L5 radiculopathy and electrodiagnostic studies identified an inactive left L4 radiculopathy.

The request was again denied by utilization review on 09/11/13 as there was insufficient evidence to support a diagnosis of lumbar radiculopathy and no documentation regarding any recent conservative treatment to include physical therapy or medication management. There were also no findings to support the use of sedation in this patient.

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

The patient has been followed for ongoing complaints of low back pain radiating to the lower extremities. The most recent physical examination findings showed very minimal weakness at the left tibialis anterior with sensory loss in the left inner thigh. Imaging studies did show evidence of a disc protrusion at L4-5 contributing to some canal and foraminal stenosis. Electrodiagnostic studies showed evidence of a chronic and inactive L4 radiculopathy. Per current evidence based guidelines, epidural steroid injections are recommended when there is clear unequivocal evidence regarding an active lumbar radiculopathy that has failed conservative treatment. The clinical documentation submitted for review does not provide evidence that the patient has recently failed to improve with any physical therapy or use of medications such as anti-inflammatories. Furthermore, the clinical documentation submitted for review is not sufficient in supporting a clear unequivocal diagnosis of lumbar radiculopathy. As such, it is this reviewer's opinion that the request is not consistent with current evidence based guidelines and medical necessity would not be established at this time. As such, the prior denials are upheld.

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

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**