

Applied Assessments LLC

An Independent Review Organization
3005 South Lamar Blvd, Ste. D109 #410

Austin, TX 78704

Phone: (512) 772-1863

Fax: (512) 857-1245

Email: manager@applied-assessments.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Sep/30/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Epidural Pain Block @ L4/5
Repeat Lumbar Spine MRI without Contrast

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

Board Certified Neurosurgeon

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)

MRI is overturned and is medically necessary
Epidural is upheld and not medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Physical therapy reports dated 08/27/12
Radiographs of the cervical and lumbar spine dated 08/02/11
MRI of the lumbar spine dated 08/02/11
MRI of the cervical spine dated 11/07/11
Radiographs of the cervical spine dated 06/20/12
Clinical report dated 12/18/12
MRI of the cervical spine dated 01/04/13
Designated doctor evaluation dated 01/16/13
Clinical report dated 04/09/13
Clinical report dated 05/28/13
Clinical report dated 06/04/13
Clinical report dated 06/11/13
Clinical report dated 07/30/13
Prior reviews dated 08/28/13 & 09/03/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx when he fell approximately 5 feet landing on his low back. The patient indicated he struck his head against the ground as well as his neck. Initial radiographs of the lumbar spine completed on 08/02/11 demonstrated facet arthrosis at L5-S1 with anterior osteophytes from L3 to L5. There was an MRI of the

lumbar spine completed on 08/02/11 which demonstrated a small posterior disc bulge with facet hypertrophy contributing to moderate foraminal stenosis. There was a small focal disc protrusion at L5-S1 with facet hypertrophy contributing to mild foraminal stenosis. The patient was noted to have been seen for physical therapy in 2012. The patient is noted to have had a prior C5-6 anterior cervical discectomy and fusion in April of 2012. The clinical report on 04/09/13 stated that the patient continued to have sharp pain in the cervical spine as well as low back pain radiating to the right lower extremity with associated numbness and weakness. Physical examination findings at this visit demonstrated decreased range of motion on flexion and extension of the lumbar spine. No motor changes were present and reflexes were full and symmetric. The patient was recommended for epidural steroid injections at this visit. The patient continued to report low back and lower extremity symptoms that were rated as severe. The patient was prescribed Diclofenac and Flexeril on 06/04/13. The patient continued to have spasms present on physical examination on 06/11/13; however, no neurological deficits at this visit were noted. Follow up on 07/30/13 stated that the patient continued to have neck pain radiating to the right upper extremity. Physical examination demonstrated numbness in a bilateral L5 nerve root distribution with positive straight leg raise findings bilaterally, left worse than right. The patient was recommended for updated MRI studies of the lumbar spine as well as epidural blocks at L4-5.

The request for repeat lumbar MRI as well as epidural pain blocks was denied by utilization review on 08/28/13 as there were no objective findings of progression in the patient's condition to warrant repeat studies and there was insufficient objective findings for neurological deficits to support injections.

The request was again denied by utilization review on 09/03/13 as there was no evidence for progression of the patient's symptoms and there were no findings to support injections.

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 right lower extremity that was severe in its intensity. The patient did not have benefits from the use of anti-inflammatories or muscle relaxers. The patient's last imaging study of the lumbar spine was from August of 2011. Given that the patient has had an increasing amount of low back pain radiating to the lower extremities and as the most recent physical examination findings were positive for sensory deficits in an L5 dermatome bilaterally, updated MRI studies of the lumbar spine would be warranted as medically necessary and appropriate per guideline recommendations. Given the absence of any updated imaging at this point in time and as the patient's objective findings are still somewhat subjective, this reviewer would not recommend lumbar epidural blocks until MRI studies have been completed. Therefore, it is this reviewer's opinion that the patient should have MRI studies of the lumbar spine completed due to new objective and subjective findings. The clinical documentation does not support epidural blocks at this point in time without updated imaging studies and this request would remain not medically necessary at this time.

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

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)