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Notice of Independent Review Decision

DATE OF REVIEW: 3/28/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of in office lumbar right L4/5 epidural steroid injection or bilateral transforaminal epidural steroid injection, no left side at office of as requested.

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 Orthopedic Surgery.

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 in office lumbar right L4/5 epidural steroid injection or bilateral transforaminal epidural steroid injection, no left side at office of as requested.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

Texas Department of Insurance

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

Records reviewed from Texas Department of Insurance

Texas Department of Insurance

Intake Paperwork

Denials- 2/7/13, 2/22/13

Records reviewed

Office Notes- 1/31/13, 9/6/12

Initial Consult- 11/10/11

Prescription- 1/31/13 (x2)

Medication/Allergy List- 1/29/13

MRI Lumbar Spine with and w/o contrast- 1/18/13

Radiology Report- 8/27/12, 8/21/12, 8/3/12

Operative Report- 8/2/12

Records reviewed from

Prospective IRO Review Response- 3/25/13

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was injured on xxxxx while exiting a vehicle while working. He reported a lower back condition. The claimant is status post a left lumbar L5-S1 discectomy on 8/02/12. A post-operative MRI of the lumbar spine from 01/18/13 revealed post-operative laminectomy at L4-5, a concentric disc bulge with mild foraminal encroachment, trace L4-L5 (and L3-L4) facet joint effusions bilaterally; an L3-L4 disc protrusion with annular fissuring and foraminal encroachment, a T12-L1 a T12-1 right paracentral disc protrusion and a L5-S1 left foraminal disc protrusion with mild left foraminal encroachment. An 8/21/12 dated MRI revealed a small left-sided disc extrusion at L5-S1. A 1/31/13 dated progress note documented back and bilateral leg pain to the knees along with painful lumbar motion and a normal neurological exam. Denial letters documented the lack of objective evidence of radiculopathy corroborated by MRI or electrical studies, along with a comprehensive trial and failure of less invasive options.

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

Recommend denial of requested services. Without objective evidence of sensory, motor and/or reflex abnormalities in the lower extremities; applicable clinical guidelines do not support the requested injection. There is no objective clinical evidence of radiculopathy corroborated by imaging and/or electrical studies. In addition, recent comprehensive less invasive treatments such as physical therapy have also not been documented. Therefore at this time, guideline criteria have not been met for the requested injection.

Reference: ODG Low Back

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

- (1) Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
- (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
- (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.

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)