

Notice of Independent Review Decision

DATE OF REVIEW: 03/21/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar ESI @L5-S1, with fluoroscopy

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

The TMF physician reviewer is board certified in anesthesia and pain management with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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 or not medical necessity exists for each of the health care services in dispute.

It is determined that the lumbar ESI @L5-S1, with fluoroscopy is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 03/07/13
- DWC Pre-Authorization Report & Notification – 02/06/13, 02/21/13
- Office Visit Notes – 11/01/12 to 01/28/13

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xxxxxx when he was hit by another driver. This resulted in injury to his hand, left knee, low back and neck. This patient has been treated with surgery, epidural steroid injections, myofascial pain management, medication management and physical therapy. The patient complains of lumbar pain radiating to the right lower extremity involving the anterior thigh with numbness. It also radiates to the left lower extremity involving the anterior thigh with numbness. There is a request for epidural steroid injections to the L5-S1 levels.

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

This patient's symptoms are for largely bilateral anterior burning thigh pain with numbness. The MRI reportedly showed disc degeneration and mild facet hypertrophy at L3/4, L4/5 and L5/S1 with an annular tear. The neurological examination was negative and the SLR was positive. The pain distribution appeared in the anterior thighs in the L2-4 dermatomes. The requested injection was at L5/S1. This does not match a specific dermatome and the requested injection site is separate from the dermatomal distribution. In addition, there are no objective signs of a lumbar radiculopathy as per the AMA and the ODG Guidelines.

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 GUIDELINE
- 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)
Page 382-382 AMA Guides to the Evaluation of Permanent Impairment, 5th edition.