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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/05/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: outpatient admission for bilateral lumbar transforaminal epidural steroid injections at L4-L5 and L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D. Board Certified Anesthesiology and Pain Management

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] 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. It is the opinion of the reviewer that the request for outpatient admission for bilateral lumbar transforaminal epidural steroid injections at L4-L5 and L5-S1 is not medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who has had a history of low back pain. From the clinical documentation provided for review, initial MRI studies of the lumbar spine performed in 12/04 revealed a subligamentous disc herniation at L5-S1 with a radial tear present in the outer annulus encroaching on the bilateral neural foramina. The patient did undergo 2 epidural steroid injections at L4-5 on 07/26/05 and 08/18/05. The follow-up on 08/25/05 indicated that the patient had post-injection headaches with no improvement in her symptoms. The patient reported an injury on 04/12/12 while lifting a large pot. The patient reported low back pain radiating to the posterior thigh.

The patient did complete a plan of physical therapy through 05/12 and MRI studies of the lumbar spine completed on 07/10/12 revealed a posterior disc protrusion at L5-S1 measuring 4.89 mm with contact of the thecal sac and no compression present. The associated annular tear resulted in a left posterolateral disc bulge and mild left neural foraminal narrowing. Upon impairment rating review in 08/12, Dr. recommended additional electrodiagnostic studies and orthopedic consults. Electrodiagnostic studies completed on 10/09/12 revealed abnormalities bilaterally at S1 and S2 as well as mild L5 involvement. It is noted that the paraspinal muscles were not tested on the report. The patient was evaluated on 11/29/12 for ongoing low back pain radiating through the left lower extremity. The patient has reported no improvements with the use of muscle relaxers, anti-inflammatories, or Hydrocodone. The patient's physical examination revealed decreased range of motion in the lumbar spine with tenderness at the intervertebral spaces at L4-5 and L5-S1. There was decreased sensation bilaterally in a L5 and S1 dermatome and straight leg raise was reported as positive bilaterally at 40 degrees. Mild to moderate weakness was noted in the lower extremities and

no reflex changes were apparent. The patient was recommended for bilateral L4-5 and L5-S1 transforaminal epidural steroid injections. An independent radiological review completed by Dr. on 12/19/12 identified a midline disc herniation at L5-S1 without deformity of the dural sac or the adjacent S1 nerve root sleeve. Dr. opined that there was some reabsorption of the disc material at L5-S1 with no evidence of foraminal stenosis on the most recent study. Dr. opined that there was no evidence to suggest that the L5-S1 lesion had worsened in the time interval from 2004 to 2012.

The requested transforaminal epidural steroid injection was found to be not medically necessary by utilization review on 12/05/12 as the patient had no response to prior epidural steroid injections and there was no documentation regarding prior physical therapy.

The request was again denied by utilization review on 01/10/13 as the patient had no response to prior epidural steroid injections in 2005 and there was no indication that the patient's symptoms had significantly progressed supporting repeat epidural steroid injections at L4-5 and L5-S1.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient reported a new injury to the low back in xx/xx after helping lift a heavy pot. The patient continued to report complaints of pain in the lumbar spine radiating to the lower extremities. There is insufficient evidence to support a diagnosis of lumbar radiculopathy in this case. The patient did report ongoing complaints of pain despite the use of physical therapy and medications. The patient's most recent physical examination from 11/12 did reveal lower extremity weakness and sensory changes; however, the lower extremity weakness appeared to be global and in both lower extremities and there were no apparent reflex changes. The electrodiagnostic study provided for review was insufficient to support a diagnosis of lumbar radiculopathy as the lumbar paraspinals were not tested. Additionally, the imaging studies of the lumbar spine from 07/12 reported no clear worsening of the disc lesion at L5-S1 and actually identified some improvements in regards to the size of the disc herniation as compared to the 2004 study. Per Dr. radiological review, this determination is consistent. As the patient did not have any significant improvements with prior epidural steroid injections at the L4-5 level and as there is no clear L4-5 pathology to support epidural steroid injections at this point in time, the request is not consistent with current evidence based guideline recommendations. As such, it is the opinion of the reviewer that the request for outpatient admission for bilateral lumbar

transforaminal epidural steroid injections at L4-L5 and L5-S1 is not medically necessary and the prior denials are upheld.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)