

Clear Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/18/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: outpatient right lumbar transforaminal epidural steroid inject L4/5 with possible adjacent level epidurography x-ray two to three views

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D. O. Board Certified Pain Medicine

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. It is the opinion of the reviewer that the proposed outpatient right lumbar transforaminal epidural steroid inject L4/5 with possible adjacent level epidurography x-ray two to three views is not supported as medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Pre-authorization/concurrent decision and rationale 12/06/12

Pre-authorization decision and rationale 12/13/12

Office/progress notes 09/20/12-11/29/12

MRI lumbar spine 10/25/12

X-rays right hip 09/20/12

X-rays lumbar spine 09/20/12

TASB prospective IRO review response 12/31/12

Pre-authorization request 12/03/12

Pre-authorization reconsideration request 12/06/12

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a male whose date of injury was xx/xx/xx. Records indicated that the claimant was injured when his vehicle was parked on the side of the road and was rear ended by another vehicle. He complained of low back pain with referred pain to the posterior aspect of the right hip. The claimant was treated with eight weeks of physical therapy, muscle relaxants, and oral corticosteroids. He continued to complain of significant back pain and right lower extremity pain. MRI of the lumbar spine on 10/25/12 revealed right paracentral 2-3mm disc protrusion/osteophyte complex at L4-5 along with mild retrolisthesis creating effacement of the thecal sac. This along with facet arthropathy created mild right lateral recess and inferior neural foraminal encroachment. The claimant was recommended to undergo right transforaminal epidural steroid injection at L4-5.

A request for right lumbar transforaminal epidural steroid injection at L4-5 with possible adjacent level epidurography x-ray two to three views was non-authorized on 12/06/12, noting that pain distribution was not consistent with MRI findings of minimal L4-5 disc bulge or broad L5-S1 disc bulge. Moreover, it was noted that MRI did not reveal any focal herniated nucleus pulposus or focal nerve root compression at any level. Physical examination revealed no evidence of radiculopathy (reflexes, strength, and sensation were all normal). Therefore, the request did not meet Official Disability Guidelines criteria for epidural steroid injection.

A reconsideration request for outpatient right lumbar transforaminal epidural steroid injection L4-5 with possible adjacent level epidurography x-rays two to three views was non-authorized on 12/13/12, noting that physical examination findings documented normal strength, sensation, and deep tendon reflexes; therefore, clinical evidence of lumbar radiculopathy was not documented. Imaging studies also did not support any significant neural compression and the request could not be certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The claimant sustained an injury to the low back secondary to motor vehicle accident in which his vehicle was rear ended on 09/13/12. He complains of low back pain radiating to the right lower extremity. He was treated conservatively without significant improvement in symptomatology. As noted on previous reviews, there was no objective evidence of focal disc herniation at any level of the lumbar spine with objective evidence of nerve root compression. Physical examination findings were unremarkable with no motor, sensory, or reflex deficits. As such, it is the opinion of the reviewer that the proposed outpatient right lumbar transforaminal epidural steroid inject L4/5 with possible adjacent level epidurography x-ray two to three views is not supported as medically necessary per Official Disability Guidelines.

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)