



Notice of Independent Review Decision - WC

DATE OF REVIEW:

07/15/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Transforaminal Epidural Steroid Injection #2, LT, L4-L5

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

Board Certified in Physical Medicine & Rehabilitation

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.

#2 Transforaminal Epidural Steroid Injection, Left – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Lumbar Spine MRI, 12/27/11
- New Patient Work Comp Evaluation, 01/11/12
- Electrodiagnostic Studies, 01/13/12
- Follow Up Visit, 6/19/12
- Review, Medical Record Review, 07/06/12
- Follow Up, 03/06/13, 05/02/13
- Procedure Notes, 04/08/13, 04/15/13
- Utilization Review Worksheet, Review, 04/26/13, 05/21/13

- Adverse Determination, Review, 05/01/13, 05/31/13
- Evaluation, 05/20/13

PATIENT CLINICAL HISTORY [SUMMARY]:

A lumbar MRI was accomplished on 12/27/11. By report, this study showed findings consistent with the presence of borderline thecal sac stenosis at the L3-L4 level. There was evidence for a disc protrusion at the L4-L5 level. The report did not describe the presence of compressive lesion upon a neural element in the lumbar spine.

The patient received an evaluation on 01/11/12. On this date, it was documented that the patient sustained an injury on xx/xx/xx when she was performing a lifting activity. She was attempting to lift a ten-pound ham to place it in a refrigerator. On this date, it was recommended that treatment be provided in the form of a left L4-L5 transforaminal epidural steroid injection (ESI). Objectively, there was documentation of good strength in the lower extremities with the exception of a slight decrease in knee flexion and dorsiflexion of the left foot.

An electrodiagnostic assessment was accomplished on 01/13/12. By report, the study revealed findings consistent with a lumbar radiculopathy that affected the L5 and S1 nerve roots.

The patient received an evaluation with a nurse practitioner, on 06/19/12. It was documented that, previously, precertification was provided for a left-sided transforaminal ESI at the L4-L5 level, but the patient did not undergo such a procedure. It was recommended that she receive access to treatment in the form of a lumbar ESI.

The patient was evaluated on 03/06/13. It was documented that a lumbar MRI had been accomplished on 10/18/12. It was documented that a Designated Doctor had evaluated the patient and this physician recommended that a lumbar ESI be provided to the patient. It was recommended that she receive treatment in the form of a lumbar ESI.

On 04/08/13, an attempt was made to provide a left L4-L5 transforaminal ESI to the patient, but an equipment malfunction prevented such a procedure from being accomplished.

A left L4-L5 transforaminal ESI was provided on 04/15/13. This procedure was performed. The patient was re-evaluated on 05/02/13. It was documented that the procedure on 04/15/13 decreased pain symptoms by approximately 65 percent. It was recommended that the patient undergo a repeat lumbar ESI.

On 05/20/13, the patient received an evaluation. On this date, she was with symptoms of low back pain and left lower extremity pain. It was documented that she had used tramadol and gabapentin for management of pain symptoms.

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

Based on the medical documentation that is presently available for review, the Official Disability Guidelines (ODG) would not presently support a medical necessity for a repeat lumbar ESI. It is documented that a lumbar ESI was provided on 04/15/13. The records available for review indicate that there was a positive response to this specific procedure. However, per the criteria set forth by the ODG, typically, there must be at least a 50 percent reduction in pain symptoms for at least six weeks prior to consideration of a repeat lumbar ESI. The records that are presently available for review do not provide documentation to indicate the amount of pain relief provided at six weeks after the procedure of 04/15/13. Hence, in this particular case, in the strictest sense the above noted reference would not currently support a medical necessity for a repeat lumbar epidural steroid injection. The records available for review do not provide documentation to indicate that there was a sufficient amount of time passed for the criteria set forth by the above noted reference whereby pain reduction was obtained to support a medical necessity for a repeat lumbar ESI.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**