

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jul/09/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

One outpatient epidural steroid injection (ESI) at the left L4, L5, and S1 levels

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

PM&R and 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 05/21/13, 06/05/13

Office note dated 05/06/13, 11/06/12, 12/12/12, 11/26/12, 09/10/12, 02/13/12, 10/12/11, 08/24/11, 07/11/11

Operative note dated 08/10/11

Lumbar MRI dated 11/06/12

Appeal letter dated 05/29/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date an adult hit her in the back at work. The patient presents with complaints of mid-thoracic paraspinal pain. The patient underwent left lumbar transforaminal epidural steroid injection at L5-S1 on 08/10/11. Follow up note dated 08/24/11 indicates that the patient reports the left side is about 50% improved, but the right is unchanged. MRI of the lumbar spine dated 11/06/12 revealed at L4-5 no disc bulge or herniation; no central canal or foraminal stenosis. At L5-S1 there is marked disc degeneration. There is a 6 mm posterior central slightly caudally migrated disc herniation; mild central canal stenosis; no foraminal stenosis. Per note dated 11/26/12, the epidural steroid injection provided 80% pain relief for one month. Follow up note dated 05/06/13 indicates that on physical examination pinprick sensation is decreased in the left L5 dermatome. Lower extremities showed bilateral 5/5 strength with normal tone except 5-/5 left anterior tibialis and 4-5/5 left EHL. Straight leg raising is negative bilaterally.

Initial request for one outpatient epidural steroid injection at the left L4, L5 and S1 levels was non-certified on 05/21/13 noting that it is a three level request which is not supported. The denial was upheld on appeal dated 06/05/13 noting that ODG endorses two level epidural steroid injections and the request is for three levels.

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

The patient underwent prior lumbar epidural steroid injection in August 2011 and reported 80% pain relief for 1 month. The Official Disability Guidelines require documentation of at least 50% pain relief for at least 6 weeks. The submitted lumbar MRI does not document any significant neurocompressive pathology. The request is excessive as the Official Disability Guidelines support two level epidural steroid injections. There is no indication that the patient has undergone any recent active treatment. As such, it is the opinion of the reviewer that the request for one outpatient epidural steroid injection at the left L4, L5 and S1 levels is not recommended as medically necessary.

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)