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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jun/18/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Epidural Steroid Injection

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

Anesthesiologist 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 01/11/13, 02/28/13, 09/07/12, 11/29/12, 09/10/12
TWCC-69 narrative dated 04/09/13
Request for examination to address certification of statutory MMI and IR dated 03/27/13
Office note dated 06/11/12, 05/15/12, 04/03/12, 03/27/12, 02/21/12, 02/03/12
Pathology consultation report dated 03/16/12
Orthopedic report dated 12/20/12, 11/15/12, 08/23/12, 01/28/13
Manual muscle strength exam dated 12/20/12
Lumbar MRI dated 12/07/12, 06/16/11
Operative report dated 03/16/12, 09/06/11
Reference material
Designated doctor exam dated 09/13/12
Radiographic report dated 12/05/11
EMG/NCV dated 11/23/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient injured his back while lifting at work. The patient underwent caudal epidural steroid injection on 09/06/11 and 10/25/11 with only temporary relief. EMG/NCV dated 11/23/11 revealed electrodiagnostic evidence of a left S1 radiculopathy. The patient subsequently underwent lumbar transforaminal discectomy at L5-S1 on 03/16/12. Per follow up note dated 03/27/12, he is 80-90% better with his radiculopathy, but has intermittent shooting pain down his legs,

buttocks and in the area of the surgery. Designated doctor evaluation dated 09/13/12 indicates that diagnosis is recurrent low back and radicular pain following minimally invasive L5-S1 disc excision on the left. The patient has not reached MMI, but in two months should be at MMI. MRI of the lumbar spine dated 12/07/12 revealed at L3-4 the spinal canal is mildly stenotic, mostly on a congenital basis. There is only minimal spondylosis. No significant foraminal stenosis is shown. At L4-5 the spinal canal is mildly stenotic due to congenital spinal stenosis and mild spondylosis. The neural foramina bilaterally are only minimally encroached. At L5-S1 mild spondylosis, annular disc bulging and bilateral facet osteoarthritis mildly encroach on the lateral recesses bilaterally. The central canal is mildly narrowed due to a combination of congenital spinal stenosis and degenerative changes. The neural foramina are moderately encroached bilaterally. The exiting L5 nerve root sheaths bilaterally appear barely contacted, but not frankly compressed. Per orthopedic report dated 12/20/12, there is severe tenderness to palpation with decreased range of motion with flexion and extension. Straight leg raises are highly positive for leg pain and back pain on the left, negative on the right. Motor strength is weakened in knee flexors and extensors, EHL, foot evertors and foot invertors. He had diminished left Achilles reflex. Reflexes were 2+ in the patellae.

Initial request for lumbar epidural steroid injection was non-certified on 01/11/13 noting that the Official Disability Guidelines recommend repeat injections with a 50% pain relief lasting at least 6 weeks. The information submitted lacks documentation of pain relief greater than 50% or the duration of pain relief of the prior epidural injections. Orthopedic report dated 01/28/13 indicates that the patient had a lumbar epidural steroid injection prior to his surgery. He has not had any injections following his surgery. The denial was upheld on appeal dated 02/28/13 noting that the documentation submitted for review details that the patient underwent lumbar epidural steroid injections prior to undergoing surgery and that the patient received a lumbar epidural steroid injection on the date of surgery intra-operatively. Subsequent clinical notes detail that the patient continues to have lower extremity radiculopathy, and the most recent clinical notes detail that in review of the patient's prior injections, the patient received 60 to 70% relief from the first injection and 60% pain relief from the second injection, which lasted only temporarily. However, the documentation submitted for review details that despite the patient having undergoing prior epidural steroid injections and receiving benefit of 60% to 70% relief, there was a lack of evidence that the patient received pain relief for at least 6 to 8 weeks. In addition, the request as stated is for lumbar epidural steroid injection; however, the number and/or which levels being requested are not stated.

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

The patient sustained injuries on xx/xx/xx. Treatment to date includes two preoperative lumbar epidural steroid injections followed by lumbar transforaminal discectomy at L5-S1 on 03/16/12. There is no updated physical examination provided to support a diagnosis of radiculopathy as required by the Official Disability Guidelines. Additionally, the request is nonspecific and does not indicate the level, laterality or approach to be utilized. As such, it is the opinion of the reviewer that the request for lumbar epidural steroid injection 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)