

Applied Assessments LLC

An Independent Review Organization
3005 South Lamar Blvd, Ste. D109 #410

Austin, TX 78704

Phone: (512) 772-1863

Fax: (512) 857-1245

Email: manager@applied-assessments.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jul/15/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4/5 and L5/S1 Intradiscal Steroid Injection with monitored anesthesia

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 04/25/13, 05/22/13, 05/08/13

Office note dated 04/18/13, 12/11/12, 10/19/12

Designated doctor evaluation dated 01/19/12

MRI lumbar spine dated 04/11/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient lifted 600 pounds when he injured his low back. Per designated doctor evaluation dated 01/19/12, diagnosis is right lumbar radiculopathy. The patient has not reached maximum medical improvement as he has persistent symptoms strongly suggestive of right lumbar radiculopathy, although he does not demonstrate muscle atrophy or reflex changes at this time. Further evaluation and possible treatment with epidural steroid injection was recommended. Anticipated MMI date is listed as 04/19/12. Note dated 10/19/12 indicates that the patient underwent bilateral L4-S1 decompression on 07/19/12. MRI of the lumbar spine dated 04/11/13 revealed at L4-5 the disc protrusion appears slightly less prominent on the current exam than on the previous exam; mild bilateral foraminal narrowing is present. A left sided laminectomy is noted compression of the canal. At L5-S1 there is no change in the retrolisthesis and disc protrusion since the prior exam. A left sided laminectomy is seen with decompression of the canal. A right sided facet effusion is present on the current examination. Moderate to marked bilateral foraminal narrowing is present right slightly worse than left. Per office visit note dated 04/18/13, current treatment includes activity modification,

medications and transforaminal steroid injection x 1. The current treatment is providing little relief of current symptoms. The patient underwent lumbar transforaminal injection on 01/28/13 at bilateral L5 and S1. The patient reported 25% pain relief for 2 weeks. On physical examination sensation is equal. There is no evidence of any weakness L1-S1. Deep tendon reflexes are 0+/5 bilaterally. Straight leg raising is noted to be positive bilaterally for low back pain.

Initial request for L4-5 and L5-S1 intradiscal steroid injection with monitored anesthesia was non-certified on 04/25/13 noting that guidelines do not recommend the use of intradiscal steroid injections as benefits have not been demonstrated compared to no treatment or epidural injections. Guidelines do not recommend the use of intradiscal steroid injections as they do not improve the clinical outcome in patients with discogenic back pain as compared to placebo. Given the lack of high quality studies to support the use of intradiscal steroid injections, the request cannot be supported. The denial was upheld on appeal dated 05/22/13 noting that the Official Disability Guidelines do not specifically recommend intradiscal steroid injections as there is minimal evidence supporting the efficacy and safety of the proposed procedure. Given that no evidence exists supporting the safety and efficacy of intradiscal steroid injections, this request does not meet guideline recommendations.

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 and has undergone treatment to include diagnostic testing, medication management, physical therapy, transforaminal epidural steroid injection and surgical intervention on 07/19/12. The patient has been recommended to undergo L4-5 and L5-S1 intradiscal steroid injection. However, the Official Disability Guidelines Low Back Chapter states that intradiscal steroid injections are not recommended. ODG states that these injections are meant to help reduce the degree the disc is herniated and producing an inflammatory response, but intradiscal steroid injections do not improve the clinical outcome in patients with discogenic back pain compared with placebo. Benefits have not been demonstrated compared to no treatment, or compared to epidural injections. There is good evidence that intradiscal steroid injection is not effective. As such, it is the opinion of the reviewer that the request for L4-5 and L5-S1 intradiscal steroid injection with monitored anesthesia is not recommended as medically necessary.

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

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

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES