

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/07/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: OP selective nerve root inj right L5-S1 w/sedation

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

D. O. Board Certified Neurological surgery

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 request for OP selective nerve root inj right L5-S1 w/sedation is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a xx year old male whose date of injury is xxxxx. On this date the patient was trying to shove some pipe over the catwalk and he fell to the ground because his low back gave out. The patient was seen and diagnosed with a lumbar sprain. The patient subsequently completed 2 physical therapy visits and no-showed for 2 other visits. MRI of the lumbar spine dated 12/05/12 revealed at L5-S1 there is normal discal height with loss of discal signal intensity due to disc desiccation. There is high signal intensity zone in the posterior aspect of the annulus due to annular fissure or tear with focal disc protrusion on the right side with impingement on the right S1 nerve root. There is

central and right sided disc protrusion with obliteration of epidural fat and impingement on thecal sac and right S1 nerve root. Central spinal canal is slightly narrowed. There is no evidence of foraminal stenosis. Physical examination on 01/04/13 notes gait is broad based. Posture is leaning forward. Range of motion is noted to be restricted. There is tenderness over the sacral vertebral and sacroiliac region.

Initial request for selective nerve root injection right L5-S1 with sedation was non-certified on 01/17/13 noting that the provider documented the patient participated in physical therapy interventions; however, no documentation to support frequency, duration or efficacy were submitted for review. The clinical notes evidence the patient has utilized chiropractic manipulation; however, active therapeutic interventions were not evidenced in the clinical notes submitted. The denial was upheld on 02/11/13 noting that the Official Disability Guidelines recommend epidural steroid injections with initial unresponsiveness to conservative treatments and IV sedation with extreme cases of anxiety. The information submitted for review lacks documentation of any physical therapy notes, objective functional improvements with measurements of range of motion and pain improvement. The information submitted for review lacks documentation of anxiety or any necessity for intravenous sedation.

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 completed only two sessions of physical therapy with two no-shows/cancellations. The patient's physical examination fails to establish the presence of active lumbar radiculopathy as required by the Official Disability Guidelines. There is no documentation of extreme anxiety or needle phobia to support intravenous sedation. Given the lack of documented radiculopathy on physical examination, lack of documentation of failure of conservative treatment, and no documentation of anxiety/needle phobia, it is the opinion of the reviewer that the request for OP selective nerve root inj right L5-S1 w/sedation 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)