

Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (817) 549-0311
Email: rm@independentresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

May/14/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Left L5/S1 Transforaminal Epidural Steroid Injection under Sedation and Fluoroscopy

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
Clinical report dated 02/21/13 signed
MRI of the lumbar spine dated 03/07/13
Clinical report dated 03/20/13 signed
Clinical report dated 03/29/13 signed
Physical therapy note dated 02/28/13
Prior reviews dated 03/28/13 & 04/11/13
Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who initially sustained an injury on xx/xx/xx. The patient reported complaints of pain in the low back radiating to the left posterior thigh. Initial treatment has included the use of a Medrol dose pack that provided temporary improvements. The patient also was seen for physical therapy and provided muscle relaxers and Ultracet for pain control. Radiographs of the lumbar spine were reported as negative for fractures. MRI studies of the lumbar spine completed on 03/07/13 identified a left paracentral disc bulge which abutted the S1 nerve root sheath, left worse than right. Moderate facet arthropathy at L5-S1 was noted and there was a 2mm synovial cyst posterior to the right sided facet joint. The patient was seen on 03/20/13 with complaints of ongoing low back pain radiating to the left lower extremity to just below the knee. Physical examination demonstrated a positive straight leg raise to the left at 60 degrees reproducing hip and back pain only. Reflexes were 2+ and symmetric. The patient did report pain with range of motion including side bending.

The patient was prescribed Norco at this visit and recommended for L5-S1 lumbar epidural steroid injections. Follow up on 03/29/13 stated the patient continued to have left lower extremity pain and weakness which did not improve with medications or physical therapy. The patient reported being unable to tolerate Hydrocodone due to excessive daytime sleepiness. Physical examination again demonstrated pain with lumbar range of motion. There was diminished sensation to touch in the left buttock. Mild weakness was also present on left hip flexion.

The requested L5-S1 epidural steroid injection with sedation and fluoroscopy was denied by a utilization review on 03/28/13 as there was no evidence of concordant findings on imaging and physical examination which would support a diagnosis of lumbar radiculopathy.

The request was again denied by a utilization review on 04/11/13 as there was insufficient evidence to support a diagnosis of lumbar radiculopathy.

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

The patient reported ongoing complaints of left sided low back pain radiating to the left lower extremity despite conservative treatments to include anti-inflammatories, narcotics, muscle relaxers, and physical therapy. MRI studies did reveal contact of the S1 nerve root sheaths, left worse than right. However, the patient's exam findings were unremarkable for any neurological deficits consistent with a L5-S1 radiculopathy. The most recent evaluation demonstrated mild weakness at the left hip with sensory loss in the buttocks. This would not be concordant with an L5-S1 radiculopathy. No further diagnostic testing to include electrodiagnostic studies were submitted for review supporting a diagnosis of lumbar radiculopathy. As current evidence based guidelines recommend there be unequivocal evidence of lumbar radiculopathy in order to support the request for epidural steroid injections and given that this is not present on the patient's exam findings, it is this reviewer's opinion that epidural steroid injections would not be supported as medically necessary per guideline recommendations. Additionally, there is no indication that sedation would be warranted with the performance of an epidural steroid injection. The clinical documentation did not indicate the patient had any significant anxiety or needle phobias that would warrant sedation for this minimally invasive procedure. As the clinical documentation provided for review does not support the requested services, it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld.

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