

SENT VIA EMAIL OR FAX ON
May/17/2013

Applied Assessments LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

May/17/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Epidural Steroid injection L3-4, L4-5 No. 2

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

Board Certified Anesthesiologist; Board Certified 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 04/08/13, 04/23/13

RME dated 03/18/13

Office note dated 04/01/13, 04/15/13, 03/05/13, 01/30/13, 11/15/12, 09/27/12, 06/21/12, 03/22/12, 01/23/12, 01/04/12, 10/03/11, 09/28/11, 08/18/11, 07/11/11, 06/14/11, 02/15/11, 01/04/11

MRI lumbar spine dated 01/25/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. The earliest record submitted for review is an office note dated 01/04/11. The patient reports he has been progressively getting worse with lumbar pain that radiates to the legs. The patient is noted to be status post L4-5 decompression, fusion and instrumentation in October 2000. MRI of the lumbar spine dated 01/25/11 revealed at L3-4 there is mild to moderate spinal stenosis secondary to bulging disc, facet disease and prominent ligamentum flavum. The neural foramen appear patent. At L4-5 there has likely been partial laminectomy at this level. There is mild canal narrowing in the transverse plane. The neural foramen appear patent. Note dated 06/14/11 indicates that the patient has had epidural steroid injections in the past, and the last one helped him about 75% for more than three months. The patient underwent lumbar epidural

steroid injection at L3-4 and L4-5 on 07/11/11. Follow up note dated 08/18/11 indicates the injection was very helpful. The patient underwent LESI at L3-4 and L4-5 on 10/03/11. Note dated 01/04/12 indicates 80% pain relief. The patient underwent LESI at L3-4 and L4-5 on 01/23/12 and reports the injection was helpful on 03/22/12. The patient subsequently underwent L3-5 and L4-5 epidural steroid injection on 03/05/13. RME dated 03/18/13 indicates that epidural steroid injections are not reasonable and necessary. He does not need any formal treatment, but will need to continue to see the doctor every 4-6 months for medication. Follow up note dated 04/01/13 indicates that he felt significant relief after the epidural steroid injection and pain level reduced from 9 to 2-3/10. On physical examination straight leg raising is positive at 35 degrees on the left and 50 degrees on the right. Motor is normal in the bilateral lower extremities. There is reduced sensation to L4, L5 and S1 dermatomal distribution on the left side. Deep tendon reflexes are normal bilaterally. Note dated 04/15/13 indicates that the patient reports 70% pain relief since the most recent injection on 03/05/13.

Initial request was non-certified on 04/08/13 noting that the patient underwent prior epidural steroid injection on 03/05/13, approximately 4 weeks ago. Current evidence based guidelines require documentation of at least 50% pain relief for 6-8 weeks. Additionally, peer review dated 03/18/13 indicates the patient is getting epidural injections which are not reasonable and appropriate. He does not need any formal treatment, but he will need to continue to see the doctor every 4-6 months for medication. The denial was upheld on appeal dated 04/23/13 noting that the patient reported more than 70% relief since the last epidural steroid injection performed on 03/05/13. While the patient has received pain reduction for more than 6 weeks, the most recent clinical evaluation does not clearly indicate that the patient has had a reoccurrence of symptoms which would warrant further epidural steroid injections as outlined by current evidence based guidelines. Additionally, the clinical documentation does not document whether the patient had any specific functional improvements following the injection or if he was able to reduce prescription medications. Without further information regarding functional improvements, medication reduction, or a recurrence of radicular-type symptoms, medical necessity is not established at this time based on guidelines.

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

The patient underwent most recent epidural steroid injection on 03/08/13 and reported 70% pain relief. However, there is no documentation of objective functional improvement or decreased medication usage. Per required medical evaluation performed on 03/18/13, epidural steroid injections are not reasonable and necessary. He does not need any formal treatment, but will need to continue to see the doctor every 4-6 months for medication. As such, it is the opinion of the reviewer that the request for lumbar epidural steroid injection L3-4, L4-5 No.2 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)