

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: May/20/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D. O. Board Certified Neurosurgery

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 injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level is not recommended as medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes 01/26/09-03/25/13
Radiology reports 04/18/08-10/07/09
MRI lumbar spine 05/08/08-02/23/13
Previous utilization reviews 04/04/13 and 04/17/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury to his low back. Clinical note dated xx/xx/xx detailed the patient complaining of low back pain. The patient was recommended for an anterior cervical fusion at C6-7 at this time. Clinical note dated 02/11/09 detailed the patient describing the initial injury as a motor vehicle accident on xx/xx/xx. The patient had neural foraminal stenosis at L4-5 and L5-S1. Clinical note dated 05/12/10 detailed the patient continuing with lumbar spine pain. The patient reported significant improvement over the previous year. Clinical note dated 01/30/13 detailed the patient having a mildly positive straight leg raise on the left. Depressed reflexes were noted in the patellar tendon on the left. MRI of the lumbar spine dated 02/23/13 revealed disc desiccation at L1-2 with a diffuse disc bulge. Facet hypertrophy was also noted causing a reduction of the right and left neural foramina. Disc desiccation was also noted at L2-3 with diffused disc bulge causing narrowing of both neural foramina. Facet hypertrophy with narrowing was noted at L3-4. A posterior disc bulge was noted at L4-5. Together with the facet joint hypertrophy, this was noted to be causing mild spinal canal stenosis and narrowing of both neural foramina. A grade 1 retrolisthesis was noted of L5 on S1. The clinical note dated 03/25/13 details the patient being recommended for an L4-5 selective nerve root block.

The previous utilization review dated 04/04/13 resulted in a denial for a selective nerve root block at L4-5 secondary to no information being submitted regarding a radiculopathy component and no information regarding the patient's completion of conservative treatments.

The previous utilization review dated 04/17/13 resulted in a denial for an L4-5 selective nerve root block as no updated physical examinations were provided establishing concordant findings with the imaging studies.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation does detail the patient having complaints of ongoing low back pain. Guidelines recommend a selective nerve root block in the lumbar spine once the patient's clinical presentation indicates radiculopathy findings. No information was submitted regarding the patient's updated clinical findings confirming reflex, strength, or sensation deficits. Furthermore, it is unclear if the patient has undergone a recent completion of conservative measures. As the recent clinical documentation does not sufficiently evaluate the patient's clinical findings indicating the necessary radiculopathy, the request for a selective nerve root block at L4-5 is not indicated. As such, it is the opinion of the reviewer that the request for injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level 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)