

# Independent Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Aug/27/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

1 lumbar epidural steroid injection under fluoroscopy and IV sedation

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical notes 04/30/12-07/15/13

MRI right hip 01/21/13

MRI lumbar spine 02/26/13

EMG/NCV bilateral lower extremities 03/11/13

CT myelogram 04/29/13

Physical performance evaluation 05/03/13

Previous utilization reviews 07/09/13 and 08/01/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who reported an injury to her low back. Clinical note dated 04/30/12 detailed the patient stating that the initial injury occurred when she tripped over a ladder and landed directly on her knees and jarred her low back. The patient described the pain as moderately severe which was restricting her movements. Pain was sharp, shooting, and throbbing at the right patella and lateral knee. Strength deficits were noted in the bilateral lower extremities. The patient had positive straight leg raise and Patrick test bilaterally. Upon exam the patient demonstrated 40 degrees of lumbar flexion, 15 degrees of extension, and 15 degrees of bilateral lateral flexion. The patient had a positive straight leg raise at 60 degrees bilaterally. MRI of the lumbar spine dated 02/20/13 revealed multilevel degenerative changes with no central canal or neural foraminal stenosis in the lumbar spine. Electrodiagnostic studies on 03/11/13 revealed bilateral S1 nerve root denervation process indicating bilateral radiculopathy. Clinical note dated 03/05/13 detailed the patient rating her pain as 6-8/10. Tightness was noted in both hamstrings. Sensation was decreased in the L5 distribution. CT myelogram 04/29/13 revealed moderate to advanced spondylosis with

degenerative disc disease at L5-S1. No significant lateral recess stenosis was noted. Clinical note dated 06/17/13 detailed the patient continuing with low back complaints. The patient had tenderness at the sacroiliac joints. The patient continued with positive Patrick test. Clinical note dated 07/01/13 detailed the patient complaining of low back pain with radiation into the buttocks. Pain was also noted at the left sacroiliac joint. Clinical note dated 07/15/13 detailed the patient being recommended for epidural block. Previous utilization review dated 07/09/13 detailed the request for an epidural injection resulting in denial as no information was submitted regarding objective findings indicating a radiculopathy component. Previous utilization review dated 08/01/13 resulted in denial for epidural steroid injection as no objective findings or radiculopathy component were noted upon clinical evaluation.

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

Clinical documentation submitted for review notes the patient complaining of low back pain. Epidural steroid injection under fluoroscopic guidance and IV sedation would be indicated provided that the patient meets specific criteria, including clinical evaluation confirming radiculopathy component. Imaging studies failed to confirm any significant neurocompressive findings. Given the lack of objective evidence supporting any neurocompressive findings, this request is not supported as medically necessary. As such it is the opinion of this reviewer that the request for lumbar epidural steroid injection under fluoroscopy and IV 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

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)