Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
Sep/16/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar epidural steroid injection with anesthesia and fluoroscopy

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:

[X] 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 08/09/13, 08/23/13, 06/20/13
Letter dated 08/27/13
EMG/NCV dated 07/18/13
Office note dated 06/24/13, 07/17/13, 07/22/13, 06/07/13, 05/23/13, 05/07/13, 08/06/13
New patient history and physical dated 06/11/13, 06/25/13
MRI lumbar spine dated 06/05/13
MMT/ROM exam dated 07/08/13

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male whose date of injury is xx/xx/xx. On this date the patient bent down and felt immediate and excruciating pain in his upper back, posterior shoulders and low back. Note dated 05/23/13 indicates that the patient completed 7 sessions of physical therapy. MRI of the lumbar spine dated 06/05/13 revealed multilevel mild to moderate facet joint disease. There is 3 mm retrolisthesis at L3-4. There are posterior disc herniations at L3-4 and L4-5 mildly narrowing the anterior thecal sac. At L4-5 there is mild impingement upon the right exiting nerve root. EMG/NCV dated 07/18/13 revealed findings compatible with right L4, L5 radiculopathy. Follow up note dated 08/06/13 indicates that the patient completed 10 sessions of physical therapy. Current medications are listed as Norco, Robaxin and Naproxen. On physical examination reflexes are present/symmetrical. Seated straight leg raising is positive on the right at 60 degrees. There is sensory change right L5 dermatome.

Initial request for lumbar epidural steroid injection with anesthesia and fluoroscopy was non-certified on 08/09/13 noting that there was no information to indicate which levels were being requested. Electrodiagnostic study showed right L4 and L5 radiculopathies. There are no specific examination findings of a specific nerve root deficit at right L4 o4 L5 and there is no documentation to indicate the need for anesthesia along with the procedure request. The denial was upheld on appeal dated 08/23/13 noting that there is no indication to support IV sedation for this patient. There is no specific level(s) being requested for tis injection.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The submitted request is nonspecific and does not indicate the level, laterality or approach to be utilized. Additionally, there is no documentation of extreme anxiety or needle phobia provided to establish the need for IV sedation. As such, it is the opinion of the reviewer that the request for lumbar epidural steroid injection with anesthesia and fluoroscopy 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)