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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
Sept/06/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Transforaminal ESI L4-S1 Right Side

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified PM&R
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 <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Employer's first report of injury or illness dated xx/xx/xx
Clinical note dated 01/13/12
Emergency room report dated xx/xx/xx
Clinical reports dated 05/22/12 – 06/05/12
Radiographs of the lumbar spine dated 06/05/12
MRI of the lumbar spine dated 06/18/12
Radiographs of the lumbar spine dated 06/19/12
Clinical report dated 06/27/12
Clinical report dated 07/19/12
Clinical report dated 08/01/12
Clinical report dated 08/06/12
Clinical report dated 08/15/12
Progress report dated 09/06/12
Clinical report dated 09/26/12
Progress report dated 10/05/12
Procedure report dated 10/11/12
Clinical report dated 11/12/12
Progress report dated 11/15/12
Clinical report dated 12/06/12
Progress report dated 12/14/12

Radiographs of the lumbar spine dated 11/15/12
Progress report dated 01/16/13
Clinical report dated 01/16/13
Electromyography report dated 03/08/13
Progress report dated 03/20/13
CT of the lumbar spine dated 03/27/13
Clinical report dated 05/07/13
Progress report dated 05/15/13
History and physical report dated 06/19/13
Progress report dated 07/09/13
Procedure report dated 07/15/13
Follow up report dated 07/22/13
Progress report dated 08/05/13
Physical therapy reports dated 08/08/12 – 01/13/13
Functional capacity evaluation dated 01/03/13
Designated doctor summary dated 07/27/12
Independent medical evaluation dated 07/16/12
Designated doctor summary dated 01/31/13
Designated doctor evaluation dated 02/27/13
Prior reviews dated 07/29/13 & 08/13/13

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who reported an injury on xx/xx/xx when she slipped injuring his right lower back. Initial MRI studies of the lumbar spine showed disc space narrowing and disc desiccation at L4-5 as well as at L5-S1 contributing to severe bilateral foraminal stenosis. The patient did have physical therapy completed through January of 2013 and the patient underwent prior facet injections. Medications were noted to include the use of Ibuprofen and Norco. The patient had reports of persistent low back pain with some lower extremity symptoms that had not improved with physical therapy, the use of anti-inflammatories, or other medications or facet injections. Electrodiagnostic studies from 03/08/13 reported findings for a chronic L4-5 radiculopathy to the right; however, EMG studies were noted to be normal on the report. CT studies of the lumbar spine completed on 03/27/13 showed spondylosis and severe loss of the disc height at L5-S1 with vacuum disc phenomenon. There was severe right foraminal stenosis as well as mild left foraminal narrowing present. At L4-5, there was moderate foraminal stenosis secondary to degenerative disc disease. The patient was evaluated on 05/07/13. Per the evaluation, the patient continued to report tenderness to palpation of the lumbar spine on the right side. The patient did have some loss of range of motion and neurological evaluation reported intact strength in the lower extremities with no sensory loss or reflex changes noted. The patient was recommended for further injection therapy at this visit. The patient did have epidural steroid injections completed at L4-5 and L5-S1 on 07/15/13. The follow up on 08/05/13 continued to show loss of range of motion in the lumbar spine. It was unclear from the report what response the patient had to the prior epidural steroid injection.

The proposed repeat epidural steroid injection to the right at L4-5 and L5-S1 was denied by utilization review on 07/29/13 as there was no indication that the patient received more than 50% relief of pain for at least 6-8 weeks as recommended by guidelines. The patient had a response for 2-3 days with return of pain.

The request was again denied by utilization review on 08/13/13 as there was limited evidence of sustained objective and functional gains from epidural steroid injections completed on 07/15/13.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The patient has been followed for an extensive amount of treatment following the injury from 2012. The patient reported ongoing complaints of low back pain with radicular features.

Imaging studies did reveal evidence of degenerative disc disease most significant at L5-S1 but to some extent at L4-5. The patient did undergo epidural steroid injections to the right at L4-5 and L5-S1; however, the clinical documentation failed to identify ongoing relief from the epidural steroid injections at least 6-8 weeks with more than 50% relief of symptoms as well as functional improvement and medication reduction. Given the limited efficacy of the epidural steroid injections, repeat injections would not be supported by current evidence based guidelines. There is an absence of clear efficacy from the epidural steroid injections initially performed on 07/15/13. Given the limited efficacy of the previous epidural steroid injections, it is this reviewer's opinion that medical necessity is not established by the clinical documentation and the prior denials are upheld.

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)