

# Clear Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Nov/10/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** epidural steroid injection lumbar

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

**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 epidural steroid injection lumbar is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. On this date he sustained a torsional injury to the low back. MRI of the lumbar spine dated 03/31/14 revealed left paracentral disc protrusion at L1-2 which mildly impresses on the thecal sac with bilateral facet arthrosis. There is a circumferential disc bulge at L2-3 which moderately impresses on the thecal sac; bilateral facet arthrosis and marked bilateral neural foraminal narrowing are noted. There is a circumferential disc bulge at L3-4 which moderately impresses on the thecal sac; bilateral facet arthrosis and moderate bilateral neural foraminal narrowing are noted. There is a circumferential disc bulge and posterior spondylosis at L4-5 which moderately impresses on the thecal sac; bilateral facet arthrosis and marked bilateral neural foraminal narrowing are noted. There is grade I retrolisthesis of L5. There is a circumferential disc bulge and posterior spondylosis at L5-S1 which moderately impresses on the thecal sac; bilateral facet arthrosis and marked bilateral neural foraminal narrowing are noted. Note dated 03/24/14 states that the patient went through physical therapy which did not help. Electrodiagnostic study dated 04/23/14 revealed evidence suggestive of a right L5 nerve root irritation. The patient underwent translaminar epidural lumbar injection on 07/15/14. Follow up note dated 07/31/14 indicates that the injection gave him pain relief for about two days. Note dated 08/26/14 indicates that the epidural steroid injection helped for one day. Physical examination on 09/30/14 notes motor strength is 5/5 throughout the lower extremities. Sensation is intact throughout. Seated straight leg raising is positive.

Initial request for lumbar epidural steroid injection was non-certified on 09/09/14 noting that there is no detailed discussion of the efficacy of prior treatment or epidural steroid injection. One epidural steroid injection treatment helped for one day. The denial was upheld on appeal dated 09/23/14 noting that the patient did not have a sustained response with the first injection. Only 2 days of pain relief was documented, and the amount of relief was not quantified. ODG guidelines state that a repeat injection should only be given if the first

injection produced “pain relief of at least 50-70% for at least 6-8 weeks.”

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained a low back injury on xx/xx/xx. The submitted records report that the patient underwent an initial course of physical therapy which was not beneficial. The patient underwent initial lumbar epidural steroid injection in July 2014. This injection provided only two days of relief. The Official Disability Guidelines require documentation of at least 50% pain relief for at least 6 weeks prior to repeat epidural steroid injection. Additionally, the current request is nonspecific and does not indicate the level, laterality or approach to be performed. As such, it is the opinion of the reviewer that the request for epidural steroid injection lumbar is not recommended as medically necessary. 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

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)