

Applied Assessments LLC

An Independent Review Organization

2771 E. Broad St. Ste. 217 PMB 110

Mansfield, TX 76063

Phone: (512) 333-2366

Fax: (512) 519-7997

Email: admin@appliedassessments.net

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

July 2, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Epidural steroid injection L3-4 with IV sedation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Orthopedic Surgeon (Joint)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. The mechanism of injury is described as suddenly turning around. The patient has a history of discectomy in 1999. Follow up note dated 03/10/14 indicates that the patient presents with low back pain with some numbness to the bottoms of both feet. Patient denies having any leg pain at this time. The patient wants to discuss having another injection to manage his pain. Current medications are listed as Norco, metaxalone, tramadol and cyclobenzaprine. On physical examination gait is stable. Strength is rated as 5/5 throughout with the exception of 4/5 left EHL. Neurologically the patient is intact to light touch in the bilateral lower extremities. The patient underwent selective nerve root block at L5-S1 in 2008. MRI of the lumbar spine dated 03/18/14 revealed at L3-4 there is anterolisthesis with facet hypertrophic changes and a less than 1 mm bulging of the annulus. There is moderate to severe central canal stenosis. There is mild right subarticular zone narrowing and mild bilateral neural foraminal narrowing.

Initial request for epidural steroid injection with IV sedation was non-certified on 04/16/14 noting that the medical records provided did not document subjective complaints of a dermatomal pain pattern nor physical examination findings noting a focal neurological deficit corroborated by imaging studies and/or electrodiagnostic testing that would support the diagnosis of a radiculopathy as required by the ODG guidelines. The denial was upheld on appeal dated 05/02/14 noting that there were no clear cut findings of radiculopathy that would identify specific nerve compromise. There was no evidence given the patient had recently

failed conservative treatment to include exercises, physical methods, NSAIDs and muscle relaxants per guideline criteria for the use of epidural steroid injections.

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

The patient sustained injuries in xx/xxxx. There is no comprehensive assessment of recent treatment completed to date or the patient's response thereto submitted for review. The patient's physical examination fails to establish the presence of active lumbar radiculopathy as required by the Official Disability Guidelines prior to the performance of an epidural steroid injection. As such, it is the opinion of the reviewer that the request for epidural steroid injection L3-4 with 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

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)