

US Decisions Inc.

An Independent Review Organization
8760 A Research Blvd #512
Austin, TX 78758
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/16/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: OP caudal epidural steroid injection @ L4-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Neurological 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 OP caudal epidural steroid injection @ L4-S1 is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. On this date she felt pain in her low back shooting down her left leg. MRI of the lumbar spine dated 10/10/13 revealed at L4-5 there is rightward disc bulge measuring 3 mm creating minimal right foraminal stenosis. At L5-S1 there is broad based posterior disc protrusion or subligamentous disc herniation measuring 4 mm creating mild bilateral foraminal stenosis without central spinal canal stenosis. Note dated 11/21/13 indicates that she had to go into aquatic therapy because land-based exercises produced excruciating pain toward the left leg. She underwent transforaminal lumbar epidural steroid injection at L5-S1 on the left on 04/29/14. Follow up note dated 05/16/14 indicates that the injection did not provide any relief. Medications are listed as Ativan, Ambien, Robaxin, Norco and metoprolol. On physical examination motor strength is 5/5 throughout. Deep tendon reflexes are hypoactive. Sensation is intact in the lower extremities. Straight leg raising is noted to reproduce radiculopathy.

Initial request for caudal epidural steroid injection at L4-S1 was non-certified on 05/22/14 noting that neurologic deficits consistent with radiculopathy specifically at L4-S1 were not documented in the latest physical examination to clinically warrant the requested epidural steroid injection. The patient stated that she did not obtain relief from prior epidural steroid injection. The denial was upheld on appeal dated 06/11/14 noting that there was no new clinical information that specifically addressed the previous reasons for non-certification. Aside from positive straight leg raising, the most recent assessment did not reflect more specific neurologic findings to support radiculopathy at the specified injection levels.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's physical examination fails to establish the presence of active lumbar radiculopathy with intact motor strength and sensation. The patient underwent prior L5-S1 epidural steroid injection on 04/29/14 and reported that the injection did not provide any relief. The submitted lumbar MRI did not document any significant neurocompressive pathology. As such, it is the opinion of the reviewer that the request for OP caudal epidural steroid injection @ L4-S1 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)