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Notice of Independent Review Decision

Date notice sent to all parties: 02/12/14

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar epidural steroid injection (ESI) at L4-L5

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Spinal 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 of the health care services in dispute.

Lumbar ESI at L4-L5 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

MRI of the lumbar spine dated 11/15/12
Discharge Instructions and prescriptions dated 06/12/13
Lumbar x-rays dated 06/12/13
Reports dated 06/13/13, 07/23/13 and 10/03/13

Operative reports dated 07/08/13 and 09/12/13
Anesthesia records dated 07/08/13
Patient Follow-up dated 07/09/13
Follow-up orders dated 07/23/13
Peer to Peer note dated 10/21/13
Reports dated 10/21/13 and 12/12/13
Utilization Review Determinations dated 10/22/13 and 12/18/13
Preauthorization requests dated 11/19/13 and 12/02/13
The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

A lumbar MRI dated 11/15/12 revealed no significant herniation, fractures, degenerative changes, stenosis, or nerve root impingement. On 06/12/13, discharged the patient from the emergency room with the diagnosis of low back pain status post MTC. X-rays that day were normal in the lumbar spine. Examined the patient on 06/13/13. She noted she had low back pain since being injured at work in xx/xxxx. She lifted something heavy and her back gave way. She had pain in the low back that radiated down the right low. She reported tingling, paresthesias, and numbness in her right leg. Her medications included Flexeril, Tramadol, Vicodin, and Ibuprofen. She had decreased thoracolumbar range of motion and radiculopathy on the right. Straight leg raising was positive on the right and negative on the left. Heel and toe walking was abnormal bilaterally. She had an antalgic gait, but strength was normal in the bilateral upper and lower extremities. The diagnosis was a lumbar strain. Meloxicam and Gabapentin were prescribed and a right sided ESI at L4-L5 was recommended. On 07/08/13, performed an ESI at L4-L5. On 07/23/13, the patient informed that she received 75% improvement following the ESI at L4-L5. She had also completed therapy. She had L4-L5 and L5-S1 midline tenderness. Bilateral radiculopathy was noted in the thoracolumbar spine. The diagnosis was a lumbar strain. A second ESI was recommended. performed an L4-L5 ESI on 09/12/13. The patient informed on 10/03/13 she had more than 75% pain relief following the two ESIs. She continued with radiating pain with right straight leg raising. Examination was unchanged. Meloxicam was continued and Voltaren Gel 1% was prescribed. A third L4-L5 ESI was recommended. On 10/22/13, provided an adverse determination for the requested lumbar ESI at L4-L5. On 11/19/13, provided a preauthorization request for procedure codes: 64483, 64484, and 77003. On 12/02/13, provided another preauthorization request for CPT codes: 62311 and 77003. On 12/18/13, provided another adverse determination for the requested lumbar ESI.

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

The patient has complaints only of lower back pain. There is no objective evidence of any abnormal neurological findings or radicular pain complaints. The

patient had a normal MRI on 11/15/12 that did not show any evidence of significant herniation, stenosis, or nerve root impingement. The ODG states that the symptoms of radiculopathy must be corroborated by imaging or electrodiagnostic studies. Her symptoms of radiculopathy are not supported by the normal MRI of 11/15/12. In the 10/03/13 examination, documented normal strength and deep tendon reflexes in the bilateral lower extremities. Straight leg raising was positive for back pain only. Furthermore, the patient has received two previous ESIs. The ODG does not support the performance of more than two ESIs either in the diagnostic or therapeutic phases.

Based on the absence of objective radiculopathy and with a normal MRI, the patient does not meet the criteria for performance of a repeat ESI. In my opinion, the lumbar ESI at L4-L5 is not medically necessary, reasonable, appropriate, or in accordance with the ODG. Therefore, the previous adverse determinations should be upheld at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ACOEM- AMERICAN 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)