

# US Resolutions Inc.

An Independent Review Organization

3267 Bee Caves Rd, PMB 107-93

Austin, TX 78746

Phone: (361) 226-1976

Fax: (207) 470-1035

Email: [manager@us-resolutions.com](mailto:manager@us-resolutions.com)

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Mar/03/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** lumbar transforaminal epidural steroid injection at bilateral L4-5 & L5-S1

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

**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 lumbar transforaminal epidural steroid injection at bilateral L4-5 & L5-S1 is not recommended as medically necessary.

### 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 patient jumped out of the way of a moving vehicle and noted low back pain. Lumbar MRI dated 09/27/13 revealed at L4-5 there is a large central disc extrusion with severe central stenosis. The extruded disc measures approximately 9 mm superior to inferior and 11 mm AP x 10 mm across. There is severe central stenosis with clumping of the nerve roots at this level. At L5-S1 there is grade I anterior spinal listhesis with bilateral pars defects. There is slight uncovering of the disc without spinal stenosis. Follow up note dated 01/10/14 indicates that pain is rated as 7/10. Medications are listed as Gabapentin, ibuprofen and Norco. On physical examination straight leg raising is positive on the left at 30 degrees and on the right at 40 degrees. Lumbar range of motion is flexion 50, extension 10, bilateral lateral rotation 20 degrees. Sensation is decreased bilateral L4, L5.

Initial request was non-certified on 01/06/14 noting that the patient has had no conservative care thus far. The MRI showed no surgical pathology at L5-S1. There is no support for monitored anesthesia care as there is no indication that the patient has any overt medical or psychiatric issues to warrant this level of care. The denial was upheld on appeal dated 01/13/14 noting that the available documentation does not demonstrate any prior conservative treatment other than pharmacotherapy. The ODG criteria for epidural steroid injections state that symptoms must be "initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)". Additionally, there is no documentation of anxiety or another psychological issue that would support the use of sedation for this procedure.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained an injury to his low back on xx/xx/xx. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no indication that the patient has been initially unresponsive to conservative treatment, as required by the Official Disability Guidelines. Additionally, there is no documentation of extreme anxiety or needle phobia to support the requested sedation. As such, it is the opinion of the reviewer that the request for lumbar transforaminal epidural steroid injection at bilateral L4-5 & L5-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)