

Clear Resolutions Inc.

An Independent Review Organization

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DATE NOTICE SENT TO ALL PARTIES: Dec/07/2015

IRO CASE #:

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

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, Board Certified PM&R, Board Certified 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 Transforaminal lumbar epidural steroid injection is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is XX/XX/XX. The mechanism of injury is described as turning. She had a previous lumbar fusion at L5-S1 in 2000. Office visit note dated 05/04/15 indicates that she does not report any upper or lower extremity symptoms. She complains of low back pain. Note dated 06/15/15 indicates that the patient reports no improvement with physical therapy. MRI of the lumbar spine dated 06/18/15 revealed at L3-4 there is a broad based disc osteophyte complex. There is moderate bilateral foraminal narrowing. There is no significant central canal compromise. At L4-5 there is a broad based disc osteophyte complex. There is mild left and moderate right foraminal narrowing secondary to subforaminal disc osteophyte complex and facet arthropathy. At L5-S1 a minimal osteophyte complex is seen. There is no significant central canal compromise. There is moderate left and mild to moderate right sided foraminal narrowing present. Note dated 08/10/15 indicates that she reports mostly back pain, but also reports pain in the left hip and left posterior thigh. On physical examination she reports equal sensation to light touch in both lower extremities. Reflexes are 1/4 at the patella and Achilles. Straight leg raising primarily causes low back pain. Office visit note dated 10/05/15 indicates that she was on light duty until June. She was terminated the prior week. On physical examination straight leg raising is negative bilaterally. There is diminished left L5 and S1 sensation. Strength and tone are normal.

Initial request for transforaminal injection of lumbosacral spine was non-certified on 10/09/15 noting that there is no MRI report in the medical records presented to be reviewed documenting any evidence of nerve root impingement or electrodiagnostic studies revealing radiculopathy. There are no physical therapy progress notes documenting lower levels of care with therapy or documentation of treatment with a neuropathic medication. There is no evidence fluoroscopy will be performed with the injection as required. Additionally, the level/levels to be injected were not specified within the request. The denial was upheld on appeal dated 11/04/15 noting that a past lumbar MRI did not reveal findings consistent with

the presence of a compressive lesion upon the neural element in the lumbar spine. The records available for review do not document the presence of signs and symptoms consistent with a lumbar radiculopathy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on xxxxx and has completed an unknown amount of physical therapy. 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 radiculopathy. The request is nonspecific and does not indicate the level/s to be injected. The submitted request fails to establish that the injection will be performed under fluoroscopic guidance. As such, it is the opinion of the reviewer that the request for Transforaminal lumbar epidural steroid injection is not recommended as medically necessary and 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)