

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Feb/17/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** right L4-5 transforaminal epidural steroid injection with fluoroscopy

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Anesthesiology 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 this reviewer that the request for a right L4-5 transforaminal epidural steroid injection with fluoroscopy is not medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** This patient is a reported male. On 03/31/14, an MRI of the lumbar spine was obtained revealing at L4-5 there was a left paracentral disc protrusion/herniation which was in contact and adjacent to the anticipated location of the descending L5 nerve root. Mild to moderate left and minimal to mild right foraminal narrowing was seen and there was a tear of the annulus fibrosis. On 03/07/14, an MRI of the lumbar spine revealed a paracentral focal disc protrusion at the L4-5 level, with questionable minimal impingement or at least abutment of the traversing left L5 nerve root within the thecal sac at that level.

On 01/07/15, the patient returned to clinic and it was noted he had had 2 months of physical therapy 3 x a week and had also completed approximately 4-5 weeks of aquatic therapy without improvement. He was taking Hydrocodone, Naprosyn, and Oxycodone as well as Cyclobenzaprine. Upon physical examination, he had decreased sensation in the right L5-S1 dermatome to light touch and he had a right straight leg raise that was positive.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** On 01/14/15, a utilization review letter noted the requested right L4-5 transforaminal epidural steroid injection with fluoroscopy was not medically necessary. It was noted that the MRI report showed left sided root impingement which did not correlate with the request nor supports doing a right sided injection. It was noted the patient had right sided radicular findings on the most current exam and on MRI at the L3-4 and L5-S1 level so an injection at L4-5 was not supported by guidelines. On 01/27/15, an appeal utilization review determination letter was submitted noting the patient had right sided radicular findings on the most current exam as well as on the MRI at L3-4 and L5-S1 levels. It was noted an injection at L4-5 was not supported. It

was noted that the MRI report shows left sided impingement which did not correlate with the request and it did not correlate with a right sided injection request.

The submitted records indicate that the MRI on 03/07/14 indicates that there is at least a question of abutment of the traversing left S1 nerve root. At the L3-4 level there is also evidence of traversing right L5 nerve root impingement. The MRI of 03/31/14 reveals at L4-5 there was a left paracentral disc protrusion which is in contact and adjacent to the anticipated location of the descending L5 nerve root. There was only mild right foraminal narrowing seen. The 01/07/15 progress note indicates the patient has right L5-S1 dermatomal distribution sensation that is reduced to light touch and a right straight leg raise is positive. Therefore, the physical findings do not correlate with the MRI studies. It is the opinion of this reviewer that the request for a right L4-5 transforaminal epidural steroid injection with fluoroscopy is not 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)