

# US Decisions Inc.

An Independent Review Organization  
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**DATE NOTICE SENT TO ALL PARTIES:** May/20/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Right L5, S1 transforaminal epidural steroid injection, radiologic exam, fluoroscopic guidance, sedation

**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 this reviewer that the requested Right L5, S1 transforaminal epidural steroid injection, radiologic exam, fluoroscopic guidance, sedation is not medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury to his low back. The clinical note dated 12/17/14 indicated the patient complaining of low back pain radiating to the right lower extremity to the top of the foot. The patient stated the initial injury occurred when he was lifting aircraft chairs on 11/10/14. The patient was utilizing muscle relaxers and non-steroidal medications for pain relief. The patient underwent physical therapy. The MRI dated 12/12/14 revealed severe right greater than left neural foraminal stenosis at L5-S1. The procedure note dated 02/18/15 indicated the patient undergoing a transforaminal epidural steroid injection L5-S1 on the right. The clinical note dated 03/09/15 indicated the patient continuing with complaints of low back pain rated 3-6/10. The previous injection was not as not effective. The clinical note dated 03/10/15 indicated the patient reporting epidural steroid injection was very helpful and alleviated right leg pain for proximally three days. The clinical note dated 03/16/15 indicated the patient continuing with 8/10 pain. The clinical note dated 05/05/15 indicates the patient continuing with radiating pain into the lower extremities. Reflex deficits were identified at the right ankle.

The Utilization Reviews dated 03/23/15 and 04/17/15 resulted in denials for repeat epidural steroid injection L5-S1 as the patient had responded with an inadequate response from the previous injection.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient complained of ongoing low back pain. The patient previously underwent right sided L5-S1 epidural steroid injection. A repeat epidural steroid injection is indicated for patients with a minimum 50% pain relief for six to eight weeks with an objective functional improvement. The patient received three days of pain relief following the initial epidural steroid injection. However, no information was submitted regarding prolonged positive response or an objective functional improvement as result of the previous injection. Given this, the request is not indicated. As such, it is the opinion of this reviewer that the requested Right L5, S1 transforaminal epidural steroid

injection, radiologic exam, fluoroscopic guidance, sedation 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)