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DATE NOTICE SENT TO ALL PARTIES: May/05/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar spine: right L5-S1 epidural steroid injection

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 the reviewer that the request for lumbar spine: right L5-S1 epidural steroid injection is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The patient fell off a ladder and on his left shoulder and back. MRI of the lumbar spine dated 12/30/14 revealed at L5-S1 there is 3 mm posterocentral disc protrusion indenting the ventral thecal sac. There is bilateral facet hypertrophy. There is no evidence of foraminal or spinal stenosis. There is no impingement. Follow up evaluation dated 01/05/15 indicates that patient states overall lumbar spine symptoms have remained the same. Pain level has remained the same. Range of motion has remained the same. Office visit note dated 01/22/15 indicates that the patient complains of low back pain radiating into the right lower extremity. The patient has undergone a course of physical therapy with minimal or no help. Office visit note dated 02/04/15 indicates that the patient underwent lumbar epidural steroid injection on this date. Office visit note dated 02/19/15 indicates that no improvement in pain is noted after the procedure which was an L4-5 lumbar epidural steroid injection. Office visit note dated 03/05/15 indicates that pain level is 7-9/10. On physical examination straight leg raising is positive on the right. There is a sensory deficit in the right L5-S1 dermatome.

Initial request for lumbar spine right L5-S1 epidural steroid injection was non-certified on 02/26/15 noting that the guidelines require unresponsiveness to conservative treatment, and there is no documentation of a home exercise program, nonsteroidal anti-inflammatories or muscle relaxants. There is no documentation of 50-70% pain relief for six to eight weeks after the last injection with decreased use of medication or increased function. No improvement was documented after the last injection. The denial was upheld on appeal dated 03/20/15 noting that the guidelines would not support repeat epidural steroid injection without 50-70% pain relief for six to eight weeks after injection. The claimant had a previous injection in February 2015 without objective documentation of decreased pain scores, decreased medication or increased function lasting six to eight weeks.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient underwent prior lumbar epidural steroid injection; however, this was performed at the L4-5 level. Therefore, there is no requirement for 6-8 weeks of improvement as this is not a therapeutic injection being requested. However, the Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The submitted lumbar MRI fails to document any significant neurocompressive pathology. MRI of the lumbar spine dated 12/30/14 revealed at L5-S1 there is 3 mm posterocentral disc protrusion indenting the ventral thecal sac. There is bilateral facet hypertrophy. There is no evidence of foraminal or spinal stenosis. There is no impingement. There is no indication that the patient has undergone electrodiagnostic testing to corroborate any physical examination findings. As such, it is the opinion of the reviewer that the request for lumbar spine: right L5-S1 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)