

Parker Healthcare Management Organization, Inc.

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DATE OF REVIEW: APRIL 15, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Lumbar Transforaminal Epidural Steroid Injection with IV Sedation
Bilateral L4-L5

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Orthopedic Surgery and is engaged in the full time practice of 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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.2	64483		Prosp	2			Xx/xx/xx	1424000949018	Upheld
724.2	77003	26	Prosp	2			Xx/xx/xx	1424000949018	Upheld
724.2	99144		Prosp	1			Xx/xx/xx	1424000949018	Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee is a male who reported sustaining an injury on xx/xx/xx, when he was reportedly bucked off a horse. X-rays of the lumbar spine were performed on January 8, 2015, documenting a Grade 1 spondylolisthesis with mild narrowing of the L4-L5 disc space and mild-to-moderate facet degeneration. A CT of the lumbar spine was performed and documented mild degenerative changes with mild anterior spurring at L4-L5 and a unilateral pars defect on the right of L4 was noted without spondylolisthesis. A posterior disc bulge was noted at L4-L5, without spinal stenosis or neural foraminal narrowing. Chiropractic treatment was reportedly provided initially for a possible fracture. Left buttock, left hip, and left thigh pain were reported. An evaluation was performed at the on February 18, 2015. The medications included Norco, Valium, and Medrol. The examination findings were not provided. An epidural steroid injection

bilaterally at L4-L5 was recommended. The request was not approved on February 24, 2015, and appealed on March 17, 2015.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

The request for the L4-L5 lumbar epidural steroid injection bilaterally would not be supported. The previous denial is upheld. The Official Disability Guidelines would not support epidural steroid injections without clinical evidence of radicular pain on examination, correlating with diagnostic imaging and failure of conservative treatment modalities. True, objective documentation of exhaustion of conservative treatment including formal physical therapy and chiropractic progress notes, activity modification and use of a nonsteroidal anti-inflammatory drug (NSAID) was not provided. Evidence of nerve root impingement was not noted on the diagnostic imaging provided. Electrodiagnostic testing confirming radiculopathy was not provided. Finally, the physical examination findings provided did not support radiculopathy, as there was a lack of substantial physical examination findings provided. Without muscle weakness, muscle atrophy, loss of reflex, and decreased sensation in a dermatomal distribution correlating with diagnostic imaging, the request would not be warranted.

ODG -TWC

ODG Treatment

Integrated Treatment/Disability Duration Guidelines

Low Back - Lumbar & Thoracic (Acute & Chronic)

Back to ODG - TWC Index

(Updated March 24, 2015)

Criteria for the use of Epidural Steroid Injection (ESI):

(NOTE: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.)

(1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, and muscle relaxants).

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)