

# Clear Resolutions Inc.

An Independent Review Organization

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**DATE NOTICE SENT TO ALL PARTIES:** Oct/26/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** #1 epidural steroid injection 5-S1

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O. Board Certified Physical Medicine and Rehabilitation

**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 1 epidural steroid injection L5-S1 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 was driving a X and hit a bump. The patient experienced immediate low back pain. Note dated xxxx indicates that he has a history of occasional stiffness in the lower back which resolved with rest. He was noted to be in physical therapy at that time. Diagnoses are listed as muscle spasm, unspecified nerve, cervicgia and backache nos. MRI of the lumbar spine dated xxxx revealed at L5-S1 there is a focal posterior disc herniation measuring approximately 6 mm with minimal left lateralization creating moderate central spinal canal and left lateral recess stenosis. Follow up note dated xxx indicates that he has completed 10 physical therapy visits. Office visit note dated xxxxx indicates that he is complaining of neck and low back pain. He has not been seen since March. Current medications are not listed. On physical examination there is increased hypertonicity of lumbar paraspinals with decreased range of motion. Straight leg raising is negative for neural traction signs. Manual muscle testing was negative. The patient was recommended to undergo lumbar epidural steroid injection.

Initial request for 1 epidural steroid injection L5-S1 was non-certified on xxxx noting that no exam notes since xxxx have been provided. The patient has back pain but no definite focal radicular deficits. The MRI from xxxxx shows bulging discs but no definite neural foraminal compromise. The denial was upheld on appeal dated xxxx noting that 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. There is no indication that the patient has received any recent active treatment.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained a low back injury on XX/XX/XX and has completed a course of physical therapy. The Official Disability Guidelines Low Back Chapter states that radiculopathy must be documented. findings on

examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. Per note dated xxxxxx, straight leg raising is negative. Manual muscle testing is negative. There are no objective findings of radiculopathy on physical examination to support the performance of an epidural steroid injection. As such, it is the opinion of the reviewer that the request for 1 epidural steroid injection L5-S1 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)