

***Applied Assessments LLC***

***An Independent Review Organization***

***Phone Number:***  
**(512) 333-2366**

**2771 E Broad St. Suite 217 PMB 110**  
**Mansfield, TX 76063**

***Fax Number:***  
**(512) 872-5096**

***Email: [appliedassessments@irosolutions.com](mailto:appliedassessments@irosolutions.com)***

***Notice of Independent Review Decision***

## ***Notice of Independent Review Decision***

**Case Number:**

**Date of Notice:** 10/02/2015

### ***Review Outcome:***

***A description of the qualifications for each physician or other health care provider who reviewed the decision:***

Physical Medicine and Rehabilitation

### ***Description of the service or services in dispute:***

Outpatient Interlaminar Epidural Steroid Injection using a Racz Catheter; Right T8-9 and T9-10, Entry at L1-2

***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)

### ***Patient Clinical History (Summary)***

The patient is a male whose date of injury is XX/XX/XX. MRI of the thoracic spine dated 04/24/15 revealed at T9-10 there is an approximate 3.5 mm central and right sided disc protrusion which causes mild right sided canal stenosis. History and physical dated xxxxxx indicates that he was when he began to experience pain. Patient states that pain is in the mid back and low back area. Previous treatments include 12 sessions of physical therapy with little to no benefit. Current medications are ibuprofen and methocarbamol. He is on light duty work. On physical examination strength is normal in the lower extremities. Deep tendon reflexes are equal and symmetrical throughout. Sensation is intact in the lower extremities. Straight leg raising is negative.

Initial request for outpatient interlaminar epidural steroid injection using a Racz catheter; right T8-9 and T9-10, entry at L1-2 was non-certified on 08/17/15 noting that the medical records do not establish specific sensory deficits on examination that are consistent with any thoracic radiculopathy. Furthermore, it remains relevant that the records do not establish evidence of a clear or significant neural compressive lesion on the MRI in the thoracic region. ODG specifically states that objective findings of radiculopathy need to be present on examination and this must be corroborated by imaging studies and/or electrodiagnostic testing. The denial was upheld on appeal dated 09/02/15 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, and the submitted MRI fails to document any significant neurocompressive pathology.

***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

The patient sustained injuries on and has completed a course of physical therapy. The Official Disability Guidelines report that epidural steroid injections are recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. ODG notes that radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. The submitted physical examination fails to document any radicular findings with normal lower extremity strength, intact sensation, equal and symmetrical deep tendon reflexes and negative straight leg raising. The submitted MRI fails to document any significant neurocompressive pathology. As such, it is the opinion of the reviewer that the request for outpatient

interlaminar epidural steroid injection using a Racz catheter; right T8-9 and T9-10, entry at L1-2 is not recommended as medically necessary.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)