



IRO REVIEWER REPORT – WC

DATE OF REVIEW: 08/31/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient Diagnostic T11/T12 Thoracic Epidural Steroid Injection

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

Board Certified in 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 or not medical necessity exists for each of the health care services in dispute:

- Outpatient Diagnostic T11/T12 Thoracic Epidural Steroid Injection - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The date of injury is listed as xx/xx/xx. On the date of injury, the claimant attempted to pick up a pallet, and the claimant developed symptoms of spinal pain. A medical document dated 04/23/15 indicated that subjectively, there were symptoms of mid back pain, described as a 5 on a scale of 1/10. In the low back region, pain was described a 0 on a scale of 1/10. Plain x-rays of the thoracic spine were described as negative. Lumbar spine x-rays were described as negative.

The records available for review indicate than an MRI obtained on 04/24/15 revealed findings consistent with the presence of disc desiccation at the T11-T12 level, with evidence of spondylosis at the T8-T9 level. There were no findings a compression legion on a neural element in the thoracic spine.

A medical document dated 05/22/15 indicated that subjectively a calendar symptoms of low back with radiation to the left lower extremities. Objectively, there was documentation of a straight leg raise test in the left lower extremity.

A medical document dated 06/12/15 indicated that subjectively, there were symptoms of spinal pain described as 0-3 on a scale of 1/10. Objectively, there was documentation of a positive straight leg raise test in the left lower extremity. It was documented that a lumbar MRI had been requested.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Based on the medical records available for review, the ODG would not support a medical necessity for a thoracic epidural steroid injection at the T11-T12 level. This reference would not support this request to be one of medical necessity as the submitted records do not provide documentation to indicate that there are signs and symptoms consistent with a thoracic radiculopathy. Additionally, a past thoracic MRI did not reveal findings consistent with a presence of a compressive lesion upon a neuro element in the thoracic spine. As such, for the described medical situation, medical necessity for this specific request would not be established per by the above noted reference.

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

- MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**