

# I-Resolutions Inc.

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**DATE NOTICE SENT TO ALL PARTIES:** Apr/01/2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** OP ASC Lumbar Epidural Steroid Injection L3/4

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD Board Certified Anesthesiology

**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 OP ASC Lumbar Epidural Steroid Injection L3/4 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 reports that he fell from a ladder and hurt his back, neck and left shoulder. The patient sustained fractures of ribs, scapula, thoracic vertebra and L3 vertebra. CT of the lumbar spine dated XX/XX/XX revealed at L3-4 there is mild narrowing of the spinal canal. Office visit note dated XX/XX/XX indicates that he has not started physical therapy yet. Note dated XX/XX/XX indicates that he has low back pain radiating into the hips. He denies any leg pain. He has no numbness. On physical examination strength is 5/5 throughout. Sensation is intact. Deep tendon reflexes are symmetrical. Note dated XX/XX/XX indicates that he is doing better. He has been doing therapy for his lower back. Office visit note dated XX/XX/XX indicates that the patient remains with low back pain despite a complete course of physical therapy. The patient was recommended to undergo a spinal cord stimulator trial. Treatment note dated XX/XX/XX indicates the patient completed 16 physical therapy visits. Physical examination on XX/XX/XX indicates that there is tenderness to palpation of the paraspinal muscles of from L2-L5 in addition to tenderness in the midline consistent with the L3 fracture. Strength and sensation are intact and equal bilaterally in the lower extremities. Straight leg raising is negative bilaterally. Neurologic exam is grossly intact. There are no focal deficits. Encounter note dated XX/XX/XX indicates that the patient is not taking any medications. The patient continues to describe low back pain with radiation to the bilateral lower extremities. On physical examination straight leg raising is positive. Strength is 5/5 in the lower extremities. There is now decreased sensation to L4 distribution bilaterally. The patient was recommended for lumbar epidural steroid injection at L3-4.

The initial request for L3-4 epidural steroid injection was non-certified on XX/XX/XX noting that the physical examination was no fully suggestive of radiculopathy along the L3-4 distribution. Neurologic examination was grossly intact. Diagnostic evidence of nerve root compromise at the specified levels for injection was not noted.

The denial was upheld on appeal dated XX/XX/XX noting that The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by

imaging studies and/or electrodiagnostic results. Given the lack of radicular findings on physical examination, medical necessity is not established.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries secondary to a fall on XX/XX/XX. The patient was subsequently treated with a course of physical therapy. The patient was subsequently recommended to undergo a lumbar epidural steroid injection at the L3-4 level. The Official Disability Guidelines Low Back Chapter reports that radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. Serial physical examinations failed to document any radicular findings on physical examination. Per note dated XX/XX/XX, the patient now has positive straight leg raising and sensory deficit in a bilateral L4 distribution. However, the submitted CT scan fails to document any significant neurocompressive pathology at the requested level. As such, it is the opinion of the reviewer that the request for OP ASC Lumbar Epidural Steroid Injection L3/4 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)