

US Decisions Inc.

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DATE NOTICE SENT TO ALL PARTIES: Jun/21/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar epidural steroid injection L4-5

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, 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 lumbar epidural steroid injection L4-5 is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is XX/X/XX. He was putting down some staging for an event. He was working on a XX and lost his footing. He had immediate pain in the right L5 distribution. MRI of the lumbar spine dated XX/XX/XX revealed at L4-5 there is a broad based posterior disc bulge with facet hypertrophy causing moderate to severe canal stenosis; mild to moderate bilateral neural foraminal narrowing. Note dated XX/XX/XX indicates that he has had physical therapy but this only gave him minimal relief. EMG/NCV dated XX/XX/XX revealed evidence consistent with chronic lumbosacral radiculopathy minimally involving the right L5 nerve root. Note dated XX/XX/XX indicates that he states he has not had any injections or physical therapy to his lumbar spine. Physical examination on XX/XX/XX notes lumbar range of motion is normal. Office visit note dated XX/XX/XX indicates that the patient complains of pain to posterior lumbar and both knees. On physical examination there is diminished touch sensation over bilateral feet. There is weakness to right lower extremity dorsiflexion and calf.

Initial request for lumbar epidural steroid injection L4-5 was non-certified on XX/XX/XX noting that there is no MRI report to substantiate the diagnosis of lumbar disc displacement, lumbar radiculopathy and stenosis. Documentation does not substantiate that medications and PT were trialed first. The date of service note dated XX/XX/XX states no physical therapy has been done. Epidural steroid injection should not be used as a standalone treatment; there should be an active treatment program along with the injection. The denial was upheld on appeal dated XX/XX/XX noting that the most recent examination by the requesting physician is incomplete without any neurological abnormalities or current clinical signs of radiculopathy. Although the EMG said there was subtle radiculopathy, there was no abnormality in the lumbar paraspinal muscles and therefore there cannot be confirmed confirmatory evidence of lumbosacral radiculopathy. Furthermore, the MRI scan shows congenital spinal stenosis but no nerve root compression.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on XX/XX/XX and has undergone diagnostic testing including MRI and EMG/NCV. However, there is conflicting evidence regarding conservative treatment completed to date. Early records state that the patient completed a course of physical therapy. However, note dated XX/XX/XX indicates that the patient stated he had not had any injections or physical therapy for his lumbar spine. There are no physical therapy records submitted for review. There is no documentation of any recent active treatment. The Official Disability Guidelines require that a patient be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, muscle relaxants & neuropathic drugs). As such, it is the opinion of the reviewer that the request for lumbar epidural steroid injection L4-5 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 & 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)