

INDEPENDENT REVIEWERS OF TEXAS, INC.

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[Date notice sent to all parties]:

06/28/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Lumbar ESI at L5-S1

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female. On X/XX/XX, an MRI of the lumbar spine was performed, and it was noted the professional dictation would be performed at an outside institution and the complete report was not submitted. On XX/XX/XX, an MRI of the lumbar spine noted at L5-S1, the central canal and neural foramina were adequate. There was mild facet disease present. On XX/XX/XX, the patient was seen in clinic. It was noted there were positive sensory deficits to the right lower extremity with 4/5 motor deficits to the right lower extremity. Straight leg raise was 90 degrees to the left and 65 degrees to the right. A lumbar epidural steroid injection at L5-S1 was recommended.

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

On X/XX/XX, a utilization review report stated the requested service was not supported, as the past lumbar MRI as well as the past electrodiagnostic assessment did not reveal finding consistent with the presence of compression lesion upon neural element in the lumbar spine.

On X/XX/XX, a utilization review report stated the requested lumbar epidural steroid injection at L5-S1 was not medically necessary, as the submitted MRI fails to document any neural compressive pathology at the requested level, there is no documentation of recent active treatment, and the peer to peer was not successful. The request is non-certified.

The guidelines state radiculopathy should be present on exam and correlated with imaging and or electrodiagnostic studies. On X/XX/XX, an MRI of the lumbar spine noted at L5-S1, the central canal and neural foramina were adequate. The EMG study of XX/X/XX did not find any lumbar radiculopathy.

It is the opinion of this reviewer that the request for a lumbar epidural steroid injection at L5-S1 is not medically necessary and prior denials are upheld.

IRO REVIEWER REPORT TEMPLATE -WC

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

- ACOEM- AMERICAN 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)**