

INDEPENDENT REVIEWERS OF TEXAS, INC.

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[Date notice sent to all parties]:

07/05/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Right transforaminal injection with IV sedation.

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

MD, Board Certified Internal Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X 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 male. On XX/XX/XX, electrodiagnostic studies were performed on of the lumbar spine and there were no findings suggestive of an L4, L5 or S1 radiculopathy. On X/XX/XX, an MRI of the lumbar spine found at L5-S1, there was a mild posterior disc bulge present, without evidence for spinal cord foraminal stenosis. Bilateral facet hypertrophy was present. There was prior anterior fusion at L3-4 and L4-5. On X/X/XX, the patient was seen in clinic with complaints of low back pain radiating to the right buttock down to his right posterior leg. On exam, he had a positive right sided tension sign, as well as bilateral L5-S1 facet tenderness. His right tibialis anterior strength was 4+, as to 5 on the left. His EHL and peroneus strength was 4/5 on the right, compared to 5/5 on the left. Patellar reflexes were 2+ and ankle jerks 1+. Light touch sensation was abnormal in an L5 dermatome.

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

On X/X/XX, an adverse determination was submitted for the right L5-S1 transforaminal injection with IV sedation, and it was noted that the request was made by submitting a code, 64483, and the request suggested a single level injection. Terminology was incorrect and ambiguous, as the requesting doctor's

notes suggested an intervention at right L5-S1 in the right L5 injection. Thus, the request was non-certified.

On X/X/XX, a reconsideration adverse determination was submitted for the requested right L5-S1 transforaminal injection with IV sedation, and it was noted the MRI failed to document significant neurocompressive pathology and the EMG nerve conduction study was not conclusive for radiculopathy. There was no documentation of recent active treatment and therefore, medical necessity had not been established and the request was non-certified.

The guidelines state radiculopathy must be established on clinical exam with correlating imaging and or electrodiagnostic studies. The MRI does not show compressive pathology at L5-S1 and the electrodiagnostic study is negative for lumbar radiculopathy.

It is the opinion of this reviewer that the request for a right transforaminal injection with IV sedation is not medically necessary and the 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**
- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- XODG- 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)**