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DATE NOTICE SENT TO ALL PARTIES: Mar/03/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Right L5 TFESI

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

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 this reviewer's opinion that medical necessity for right L5 TFESI has not been established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who was injured on XX/XX/XX when she was knocked to the ground by a vehicle. The patient described immediate onset of back pain and right leg pain. The patient described her pain as radiating through the posterolateral thigh as well as the anterolateral lower leg to the top of the foot. The patient described difficulty walking due to her symptoms. Prior treatment included oral steroids, muscle relaxers, and tramadol for pain. The patient was evaluated by physical therapy in XX/XXXX. No physical therapy summary reports or discharge evaluations were reported were available for review. MRI studies of the lumbar spine from XX/XXXX noted grade 1 degenerative spondylolisthesis of L4 and L5 with facet arthropathy that contributed to some mild neural foraminal narrowing bilaterally. The patient was followed for continuing right lower extremity complaints. The XX/XX/XX clinical record noted ongoing pain. The patient's physical examination noted weakness at the right tibialis anterior. The requested epidural steroid injection was denied by utilization review as there was no clear evidence on physical examination or imaging studies to support a diagnosis of an active lumbar radiculopathy. There was also no clear documentation regarding conservative management for the patient.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical records submitted for review noted ongoing complaints of low back pain radiating to the right lower extremity. The patient's MRI studies of the lumbar spine noted some mild neural foraminal narrowing at L4-5 due to a combination of degenerative spondylolisthesis and facet changes. The patient's most recent physical examination reported progressive weakness to the right at the tibialis anterior. The patient's MRI findings did not identify any evidence of nerve root impingement or encroachment. There was no other supportive evidence for an active right L5 radiculopathy such as electrodiagnostic studies. Current guidelines recommend that there be unequivocal evidence regarding lumbar radiculopathy to support epidural steroid injections. This has not been substantiated by clinical records submitted for review. Furthermore, the records noted prior use of oral steroids without any specific documented results. The patient also recently underwent a physical therapy evaluation XX/XXXX and there is no indication

from the records that the patient had failed to improve with physical therapy prior to considering epidural steroid injections as recommended by guidelines. As the clinical records submitted for review do not meet guideline recommendations regarding proposed procedure, it is this reviewer's opinion that medical necessity for right L5 TFESI has not been established and the prior denials remain 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)