

Clear Resolutions Inc.

An Independent Review Organization

6800 W. Gate Blvd., #132-323

Austin, TX 78745

Phone: (512) 879-6370

Fax: (512) 519-7316

Email: resolutions.manager@cri-iro.com

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

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Lumbar epidural steroid injection left L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, 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 this reviewer that the request for lumbar epidural steroid injection left L5-S1 is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male. On XX/XX/XX, the patient was seen with complaints of low back pain radiating to the left lower extremity. He had undergone physical therapy without significant benefit. On exam, straight leg raise was positive on the left and there was a sensory deficit in a left L5-S1 dermatome. The patient requested anesthesia during epidural steroid injection as he had a degree of anxiety about needles. On XX/XX/XX, an MRI of the lumbar spine was obtained and at L5-S1 there was a moderate to marked facet arthropathy with ligamentum flavum hypertrophy, but no evidence of disc herniation or central canal stenosis. Lateral recess narrowing without anatomic impingement was noted upon the foraminal zone segment of either L5 nerve root. On XX/XX/XX, the patient returned to clinic, and there was no significant change in the physical examination and lumbar epidural steroid injection at L5-S1 on the left times one was recommended. The patient had a degree of anxiety for which sedation was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, a peer review report stated that the diagnosis requires a dermatomal distribution of pain, numbness and or paresthesia, and the reflexes are said to be diminished in the left lower extremity with also heel and toe walking being poor. Examination findings of the lower extremity did not correlate with a specific nerve root level at L4-5 level. In the absence of objective right radiculopathy, the request would not be supported. Furthermore, the most recent imaging study did not establish neural compression lesions to support the diagnosis of radiculopathy. The request was non-certified.

On XX/XX/XX, a peer review report stated that radiculopathy must be corroborated by imaging studies and or electrodiagnostic studies and should be documented on physical examination. The imaging study did not demonstrate evidence of neural compromise that would corroborate with the patient's subjective complaints or clinical findings. Therefore the request was non-certified.

The guidelines state radiculopathy should be documented on exam, with corroborating imaging and or electrodiagnostic studies. The MRI shows no specific neural compression to warrant this procedure.

It is the opinion this reviewer that the request for lumbar epidural steroid injection left L5-S1 is not 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)