

US Decisions Inc.

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DATE NOTICE SENT TO ALL PARTIES: Feb/22/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Transforaminal ESI L4-5, L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, 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 Transforaminal ESI L4-5, L5-S1 has not been established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on XX/XX/XX and has been followed for ongoing complaints of low back pain. The patient is noted to have had a prior lumbar spine fusion procedure. Radiographs from XX/XX/XX noted post-operative changes at L4-5 and at L5-S1. The patient had been followed for ongoing complaints of low back pain radiating to left lower extremity including the anterolateral thigh as well as the calf. Interval conservative treatment included the use of tramadol. It is noted that patient had undergone previous epidural steroid injections in the past with temporary response only. MRI studies of the lumbar spine from XX/XX/XX noted post-operative changes at L4-5 and L5-S1 consistent with lumbar decompression and fusion. The report noted moderate foraminal encroachment at L4-5 that appeared stable. At L5-S1 there was some neural foraminal stenosis present as well; however, the report indicated that this was also stable. The last clinical evaluation was on XX/XX/XX. The patient's physical examination noted tenderness in the lumbar region with intact strength in the lower extremities. There was continued hypersensitivity at the left anterolateral thigh and medial calf. Positive straight leg raise signs were noted to the left side as well. The requested epidural steroid injections were denied due to the limited objective evidence of radiculopathy and limited response to prior epidural steroid injections.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient continues to complain of radicular pain following a two level lower fusion from L4 through S1. Recent imaging studies noted some continuing neural foraminal encroachment bilaterally at both the L4-5 and L5-S1 levels. There was no clear evidence of nerve root impingement or compression on the MRI study.

The patient's physical examination findings noted hypersensitivity in the left lower extremity with positive straight leg raise findings; however, there was no motor weakness, sensory deficits, or abnormal reflexes indicated on physical examination that would meet guideline criteria regarding lumbar radiculopathy involving the L4-5 or L5-S1 levels. No electrodiagnostic evidence was provided for review regarding evidence of an ongoing

radiculopathy at either L4-5 or L5-S1. Overall the records do not clearly indicate the presence of an active lumbar radiculopathy that would meet guideline recommendations regarding epidural steroid injections. The records also indicate limited response to previous epidural steroid injections, which would not lend further support for repeating this type of modality. Therefore, it is this reviewer's opinion that medical necessity for Transforaminal ESI L4-5, L5-S1 has not been established. As such 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)