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DATE NOTICE SENT TO ALL PARTIES: Mar/17/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left L4 and L5 Transforaminal Epidural Steroid Injection Fluoroscopy, epidurography, sedation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE

PROVIDER WHO REVIEWED THE DECISION: DO, 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 of the reviewer that the request for left L4 and L5 Transforaminal Epidural Steroid Injection Fluoroscopy, epidurography, sedation is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is XX/XX/XX. The patient fell through a single story roof. Physical therapy was ineffective in relieving the pain. MRI of the lumbar spine dated XX/XX/XX revealed at L4-5 there is a 3 mm retrolisthesis and a broad 3 mm disc protrusion/herniation with a 4.5 mm central and left paracentral component. There is left L5 nerve root impingement with posterior displacement of the nerve root and very mild thecal sac stenosis. Mild right neural foraminal narrowing and moderate left neural foraminal narrowing are appreciated. EEG dated XX/XX/XX is a normal study. The patient underwent left L4-5 epidural steroid injection on XX/XX/XX. Progress note dated XX/XX/XX indicates that the patient reported relief for 1 week after the injection. Progress note dated XX/XX/XX indicates that the patient reported marked improvement for 2 weeks following the injection before pain started to return. Progress note dated XX/XX/XX indicates that the patient presents with low back pain rated as 3-8/10. The pain radiates to the left leg. He has been recently treated with a lumbar transforaminal epidural steroid injection. The patient reported that he had 100% relief for 1 week after the injection. Current medications are cyclobenzaprine and Tylenol-codeine. On physical examination lumbar range of motion is mildly reduced with mild pain. Facet loading causes pain. Straight leg raising is positive on the left. Strength is 4/5 left dorsiflexion. Sensation is impaired to light touch in the left lower extremity L4-5 distribution. Assessment is lumbar radiculitis. Initial request for left L4 and L5 transforaminal epidural steroid injection fluoroscopy, epidurography, sedation was non-certified on XX/XX/XX noting that MRI of the lumbar spine dated XX/XX/XX revealed at L4-5 there is 3 mm retrolisthesis and a broad 3 mm disc protrusion/herniation with a 4.5 mm central and left paracentral component causing mild right neural foraminal narrowing and moderate left neural foraminal narrowing as well as definite left L5 nerve root impingement with very mild thecal sac stenosis. Progress note dated XX/XX/XX indicates that he has previously been treated with physical therapy. The physical therapy was ineffective in relieving the pain. The patient underwent left L4 and L5 transforaminal epidural steroid injection on XX/XX/XX. Progress note dated XX/XX/XX

indicates that the patient reported only one week of relief following lumbar epidural steroid injection. Progress note dated XX/XX/XX indicates that he has been recently treated with lumbar transforaminal epidural steroid injection. The patient reported 100% relief for 1 week. On physical examination sensation is impaired in the right L4 L5 distribution. There is 4/5 dorsiflexion strength on the left. The Official Disability Guidelines require documentation of at least 50% pain relief for at least 6 weeks prior to repeat epidural steroid injection. The patient reported pain relief for only one week following previous L4-5 epidural steroid injection on XX/XX/XX. Therefore, medical necessity is not established in accordance with current evidence based guidelines. The denial was upheld on appeal dated XX/XX/XX noting that the guidelines state that if the initial block was found to reduce pain relief of at least 50-70% relief for at least 6-8 weeks, additional blocks may be supported. With this patient having the procedure and then returning without documented 50-70% pain relief for 6-8 weeks, the request on appeal is not supported and the issues raised on initial determination have not been resolved.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on XX/XX/XX as a result of falling through a single story roof. The patient was treated with physical therapy and a left L4-5 epidural steroid injection on XX/XX/XX. The Official Disability Guidelines note that if after the initial block/blocks are given and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. Progress note dated XX/XX/XX indicates that the patient reported relief for X week after the injection. Progress note dated XX/XX/XX indicates that the patient reported marked improvement for 2 weeks following the injection before pain started to return. Progress note dated XX/XX/XX indicates that the patient reported that he had 100% relief for 1 week after the injection. Given the lack of documentation of at least 50-70% pain relief for at least 6 weeks following the initial left L4-5 epidural steroid injection, medical necessity is not established for repeat epidural steroid injection in accordance with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for left L4 and L5 Transforaminal Epidural Steroid Injection Fluoroscopy, epidurography, sedation is not recommended as 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 KNOWLEDGBASE
- 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)