True Decisions Inc.
An Independent Review Organization
Phone Number: **(512) 298-4786**
2771 E Broad St. Suite 217 #121
Mansfield, TX 76063
Email:truedecisions@irosolutions.com
Fax Number: **(512) 872-5099**

Notice of Independent Review Decision

Case Number: *Date of Notice:* 01/11/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Neurosurgery

Description of the service or services in dispute:

Epidural Steroid Injection L3/4 and L4/5 with IV Sedation

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)

Patient Clinical History (Summary)

The patient is a female who presented on XX/XX/XX regarding low back pain. The patient had a history of lumbar MRI findings of mild narrowing and a desiccation of the disc with protrusion that was broad based, producing mild stenosis secondary to mild decompression of the thecal sac at the L3-4 level, L5-S1 slight narrowing with desiccation of the disc, and an L4-5 protrusion/herniation of the disc producing marked compression of the thecal sac. Per the notes provided, the patient attended physical therapy in 2012 but then stopped. She also underwent 2 caudal epidural steroid injections at the L3-4 and L4-5, one on XX/XX/XX and one on XX/XX/XX. During her visit she reported pain rated at an 8/10 with numbness and tingling into the right leg and weakness into both legs. Per the note the patient had significant improvement of her symptoms following the XX/XXXX injection. Her medications at the time included Norco, Prozac, Cymbalta, Clonazepam, Flexeril and Naprosyn. Upon physical examination, gait and station were markedly antalgic. Motor strength was 5/5 in all muscle groups and sensation was normal in the upper and lower extremities. Range of motion was limited in flexion, extension and lateral tilting of the lumbar spine and there was evidence of tenderness and spasm to palpation. She was diagnosed with radiculopathy of the lumbar region, chronic pain syndrome, other intervertebral disc displacement and low back pain.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The requested epidural steroid injection at the L3-4 and L4-5 with IV sedation is not supported. Per the Official Disability Guidelines recommendations, repeat epidural steroid injections are based upon continued objective documented pain and functional improvements, including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks, with a general recommendation of no more than 4 blocks per region per year. The patient's most recent injection took place in XX/XXXX. However, documentation of her response to the injection showing continued pain relief and functional improvement with at least a 50% pain relief and associated reduction of medication use for 6 to 8 weeks, was not provided within the clinical documentation submitted. Also, sedation per the guidelines, is only supported for patients with extreme anxiety. There was no mention of the patient having extreme anxiety to warrant the use of sedation during

the procedure. There was also no clear rationale as to why oral forms of sedation could not be used, such as a benzodiazepine agent. Due to the above, the request is not supported per evidence based guidelines. As such, this request is upheld and not considered medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low Back Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)