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

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Lumbar Epidural Steroid Injection L5/S1 times one (1) under fluoroscopy with anesthesia

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:

[X] 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 this reviewer that the request for a Lumbar Epidural Steroid Injection L5/S1 times one (1) under fluoroscopy with anesthesia is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his low back. The CT strength at the clinical note dated XX/XX/XX indicates the patient complaining of ongoing low back pain. The patient reported radiating pain into the right lower extremity. The patient rated the pain as 5/10. No strength, sensation no strength at there is indication the patient also had cervical involvement. Strength deficits are identified in the upper ex left upper extremity. Reflex and sensory deficits are also identified in the left upper extremity. The procedure note dated XX/XX/XX indicates the patient undergoing a procedure at the cervical region to include removal of the titanium plate at the C5, C6 and C7 levels. The MRI of the lumbar spine dated XX/XX/XX revealed disc desiccation at L5-S1 with a central disc protrusion measuring 1.3cm extending approximately 0.5cm. No evidence of canal stenosis or nerve root impingement was identified. A mild right lateral recess narrowing was identified. The therapy note dated XX/XX/XX indicates the patient continuing with complaints of both cervical and lumbar complaints. Range of motion deficits were identified throughout the lumbar spine. Strength deficits were identified at the right knee with specifically with flexion/extension. The clinical note dated XX/XX/XX indicates the patient continuing with neck and low back complaints. The note indicates the patient reporting a two year history of complaints in both regions. The note indicates the patient utilizing Flexeril, Tylenol #4 as well as Lyrica for ongoing pain relief. The patient rated the pain as 7/10 at that time. The patient was able to heel and toe ambulate without difficulty. No reflex or sensation deficits were identified. The clinical note dated XX/XX/XX indicates the patient continuing with 7-9/10 low back pain. Rating pain was identified into the right lower extremity. There is indication the patient had sensory deficits along the right L5-S1 dermatome. The letter of appeal dated XX/XX/XX indicates the patient continue be recommended for an epidural steroid injection L5-S1. The patient describe a pulling, aching, numbness and tingling sensation. The patient rated the ongoing low back pain as 7-9/10 at that time. The clinical note dated XX/XX/XX indicates the patient a rating the ongoing pain as 7-9/10. The patient described radiating pain into the right lower extremity. On okay the

The utilization reviews dated XX/XX/XX and XX/XX/XX resulted in denials as minimal information was submitted regarding the patient's completion of a full course of conservative therapy and minimal information was submitted confirming the patient's presence of radiculopathy as well as neurocompressive findings confirmed by imaging study.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of ongoing low back pain. On an epidural steroid injection in the lumbar region is recommended provide the patient meets specific criteria to include imaging studies confirming the patient's significant neurocompressive findings at appropriate level and the patient continues with fines consistent with radiculopathy following depletion of a full course of conservative therapy. The MRI revealed mild findings at the right neural foramen at the L5-S1 level. There is also an indication the patient has decrease sensation along the right L5 and S1 distribution. However, no information was submitted regarding the patient's recent completion of any conservative therapies addressing the lumbar complaints. Given the minimal information regarding the patient's completion of any conservative therapies addressing the lumbar complaints to include a recent completion of a full course of conservative therapy, the request is not indicated as medically necessary. As such, is the opinion of this reviewer that the request for a Lumbar Epidural Steroid Injection L5/S1 times one (1) under fluoroscopy with anesthesia 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 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)