Notice of Independent Review Decision - WC

IRO REVIEWER REPORT
DATE OF REVIEW: 07/29/18

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right L5-S1 transforaminal ESI under fluoroscopy guidance

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified in 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 or not medical necessity exists for each of the health care services in dispute:

- Right L5-S1 transforaminal ESI under fluoroscopy guidance - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The date of injury is listed as XX. It is documented that on the date of injury the claimant sustained XX in the workplace.

A lumbar MRI scan was accomplished on XX and revealed findings consistent with the presence of early degenerative changes at the L4-L5 and L5-S1 levels, with small annular fissure at these levels.

A left knee MRI scan was accomplished on XX and revealed findings consistent with the presence of a minimal left knee effusion with early formation of a Baker's cyst. There was documentation of no ligamentous or meniscus tears in the affected knee. There were findings consistent with what was described as a mild sprain of the anterior cruciate ligament and possible nonspecific mild bone bruise/strain involving the inferior aspect of the patella.

The claimant was evaluated by XX on XX. On this date, it was documented that previous treatment did include an attempt at physical therapy services, as well as prescription medication management that did include utilization of XX Objectively, there was documentation of a nonfocal neurological examination. It was documented that no assistive device was required for walking activities.

The claimant was evaluated by XX on XX. On this date, there were symptoms of low back pain with radiation to the right lower extremity. Objectively, there was documentation of an antalgic gait pattern. The neurological examination was described as nonfocal. There was a documented diagnosis of lumbar sprain.

The claimant received an evaluation from XX on XX. Subjectively, there were symptoms of pain in the low back region with radiation to the right hip. Objectively, there was documentation of an antalgic gait pattern with limited range of motion in the spinal region. There was documentation of decreased sensation in the right L4 and L5 nerve root distributions. There was a documented diagnosis of lumbar sprain.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Based upon the medical documentation presently available for review, Official Disability Guidelines would not support a medical necessity for treatment in the form of a lumbar epidural steroid injection as requested. At the present time, this reference would not support a medical necessity for this specific request, as there is no documentation of a compressive lesion upon a neural element in the lumbar spine or objective diagnostic testing that is available for review. There is no documentation to indicate that there is a correlation of the documented symptoms with respect to objective diagnostic test results. Consequently, given the fact that there is no a corroboration with regard to objective diagnostic test results with subjective symptoms and objective findings on physical examination, the above-noted reference would not support a medical necessity for treatment in the form of lumbar epidural steroid injection as requested. As such, the prior denials are upheld as the requested service is not supported as medically necessary at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☒ **ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**