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IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Epidural Steroid Injection Right L5-S1

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|--------------------------------|
| <input type="checkbox"/> Overturned | Disagree |
| <input type="checkbox"/> Partially Overturned | Agree in part/Disagree in part |
| <input checked="" type="checkbox"/> Upheld | Agree |

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a XX-year-old male with a history of an occupational claim from XXXX. The mechanism of injury was detailed as XXXX breaking his left scapula and shoulder. The patient also had complaints of low back pain radiating into the legs. The documentation does indicate the patient has had a previous MRI on XXXX showing a 1 mm diffuse annular bulge without central/lateral recess stenosis or neural foraminal narrowing. On XXXX the patient was seen for a follow-up. This visit was in regard to left shoulder pain. The documentation indicated the patient was agreed to participate in therapy for his low back at that time and was recommended to discontinue the sling. On XXXX the patient was seen with complaints of radiating pain into the right lower extremity and no changes on exam. The recommendation was made to appeal the previous denial of the epidural injection. On XXXX the patient was seen for a consultation complaining of low back pain radiating into the bilateral extremities. The documentation indicated he has had physical therapy medication without any significant benefit. The examination revealed a positive bilateral straight leg raise with diminished sensation in the L5-S1 dermatome bilaterally. He also decreased range of motion to the bilateral spine. The physician recommended a diagnostic epidural injection at the L5-S1 level to the right $\times 1$ followed by additional physical therapy. If this injection does help consideration would be made into a therapeutic injection.

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

The submitted documentation indicates this case involves a XX-year-old male with history of an occupational

claim from XXXX. The mechanism of injury was detailed as XXXX breaking his left scapula and shoulder. The patient also continued to complain of low back pain and radiation to the bilateral lower extremities. He has undergone an MRI showing a 1 mm diffuse annular bulge without recess stenosis or neural foraminal narrowing. The patient was seen for consultation on XXXX and the request was made for a diagnostic epidural injection. On examination the patient did have a positive bilateral straight leg raise with diminished sensation in the L5-S1 dermatomes bilaterally. According to referenced literature the utilization of a diagnostic injection is to determine the level of radicular pain in cases with diagnostic imaging is ambiguous. Within the documentation there is indication pathology on MRI. Although not significant it appears the patient's symptoms correlate with the findings given the patient has radiculopathy on objective examination. Therefore, there is no indication of why a diagnostic injection at this time would be necessary. As such, the previous denial is upheld.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
 - AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
 - MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
 - MILLIMAN CARE GUIDELINES
 - ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
 - OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
 - PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
 - PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
 - TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
 - TEXAS TACADA GUIDELINES
 - TMF SCREENING CRITERIA MANUAL
- Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Low Back/Epidural steroid injections, diagnostic