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An Independent Review Organization

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IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left L4-5 tranforaminal epidural steroid injection with selective nerve root block

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

REVIEW OUTCOME:

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

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

PATIENT CLINICAL HISTORY [SUMMARY]: This case involves a XXXX with a history of an occupational claim from XXXX. Mechanism of injury was detailed as a XXXX. The patient's diagnoses included lumbar sprain/strain and lumbar intervertebral displacement. Patient a transforaminal epidural steroid injection at the L4-L5 with selective nerve root injection on XXXX. The patient was then evaluated on XXXX. Was documented that the patient had 100% relief of left leg radicular pain however continued to have intermittent left burning pain not consistent with any particular pattern. XXXX was noted that the patient was initially treated with physical therapy that had to be discontinued secondary to pain. Objective findings included restricted range of motion secondary to pain. The patient had decreased reflexes in the posterior tibialis bilaterally patellar left-sided reflexes, and Achilles left-sided reflexes. The treatment plan included continuation of conservative therapy and consideration of surgical management. The request was submitted for an additional epidural steroid injection. This request was previously reviewed and received an adverse determination due to a lack of documentation of diagnostic imaging. An appeal was submitted and the original denial was held secondary to a lack of documentation of how long the previous injection provided relief. According to the submitted documentation the patient underwent a lumbar spine MRI on XXXX. Was documented that the patient had spondylolisthesis at the L5 and a disc bulge impinging at the left L5 nerve root at the L4-L5. The patient was later evaluated on XXXX. The patient presented with low back pain rated at an 8 out of 10. Was noted that physical therapy did not assist with pain relief. Was noted that patient had undergone L4-L5 transforaminal steroid injection with an L5 selective nerve root block on XXXX that provided 100% pain relief of left-sided radicular symptoms. It was noted that the patient continued to complain of left foot burning pain. The patient's treatment plan included continued use of medications, additional physical therapy, and a left-sided L4-L5 transforaminal epidural steroid injection with selective nerve root block due to an escalation in symptoms.

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

The Official Disability Guidelines recommend epidural steroid injections be repeated for patients who have at least 50% pain relief for 6-8 weeks. The clinical documentation submitted for review does indicate that the patient was evaluated 2 weeks after the injection with 100% pain relief of radicular symptoms. The patient was again evaluated in XXXX and an escalation in symptoms was documented. Given that the patient's clinical presentation is consistent with pathology identified on diagnostic imaging and the patient had a favorable response to the previous injection, an additional injection would be supported.

As such, the requested left L4-L5 transforaminal epidural steroid injection with selective nerve root block is medically necessary and certified.

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 Chapter, Epidural steroid injections (ESIs), therapeutic