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An Independent Review Organization
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Description of the service or services in dispute:
Left L5/S1 Therapeutic lumbar epidural steroid on left.

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified Anesthesiology

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

- ☑ Overturned (Disagree)
- ☐ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)
The patient is XXXX . XXXX was injured on XXXX, while XXXX was XXXX, when the XXX and XXXX twisted to XXXX left to catch it causing immediate pain to XXXX left side hip and lower back. XXXX was diagnosed with lumbar sprain/strain.

Per a physical therapy note dated, XXXX, the patient reported pain while XXXX. The pain was rated as 6/10 and was present in the lower left lumbar region. XXXX was not able to perform recreational activities independently. Active lumbar spine range of motion showed extension 20 degrees and right side bending 20 degrees. The compression, thigh thrust and sacral thrust tests were positive. The symptoms were likely related to the sacroiliac joint. Joint mobility showed hypomobility and pain at the left sacroiliac joint. Sacrum was in counternutation.

On XXXX, the patient was status-post epidural steroid injection and reported getting significant relief over 50%, which remained for two months, but after that the pain continued. XXXX wanted to get another injection. The pain was increased with prolonged walking. Per DWC-73 Form, XXXX was allowed to return to work as of XXXX with the restrictions, which were expected to last through XXXX. The restrictions included XXXX.

Treatment to date consisted of medications, therapeutic lumbar epidural steroid injection and physical therapy.

EMG/NCV study dated XXXX showed abnormal EMG findings in anterior tibialis and vastus medialis, consistent with mild axonal injury to the left L4-L5 and L5-S1 nerve roots. Negative bilateral tibial H-reflex ruled out S1 radiculopathy.

An MRI of the lumbar spine dated XXXX revealed, L5-S1 desiccation and loss of normal water content. A 4 mm central and left-sided disc herniation with some narrowing of the left L5-S1 intervertebral foramen was noted.

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

I am overturning the two prior review decisions and **approving Left L5/S1 therapeutic lumbar epidural steroid injection with sedation/anesthesia**. A diagnostic ESI with sedation/anesthesia was approved in XXXX – the result documented the requisite quantification of pain reduction, effects on function, effects on medication ingestion and duration of the effect. A repeat injection, which is now therapeutic, was requested based on the response to the diagnostic ESI in XXXX. The ODG states that "If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase.""

In the XXXX review, by XXXX, , the reviewer noted that there was no objective documentation in terms of the decreased pain scale and decreased need for pain medications to validate the subjective report of relief. However, there was such documentation in XXXX notes. In addition, there was no documentation of new onset of radicular symptoms to warrant repeat injection. However, new onset of radicular symptoms is not a criterion for a repeat ESI. Furthermore, there was also no objective assessment of patient's level of anxiety in the medical report to support the use of sedation. However, sedation was approved during the first procedure, on the basis of extreme anxiety.

In the XXXX review, by XXXX, there was lacking documented evidence of pain relief of at least 50 percent for six weeks, decreased need for pain medications and functional improvement. However, there was such documentation in XXXX notes.

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
- ☐ AHRQ-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 Medical Literature (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

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