Applied Independent Review

An Independent Review Organization

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A description of the qualifications for each physician or other health care provider who reviewed the decision:
Anesthesiology and Pain Management

Description of the service or services in dispute:
Lumbar epidural steroid injection (ESI) at L5-S1

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)

Patient Clinical History (Summary)

This case involves a XXXX with a history of an occupational claim from XXXX. The patient was injured when XXXX. XXXX was diagnosed with low back pain. An MRI of the lumbar spine performed on XXXX revealed a 5.5 mm posterior disc protrusion at L5-S1, impinging on the left greater than right S1 nerve root approaching the thecal sac and narrowing the medial aspect of the neural foramen on both sides. According to the submitted documentation, the patient had previously been recommended for a lumbar epidural steroid injection at L5-S1, although the request had been denied as there was no physical examination evidence of lumbar radiculopathy corresponding with compression at the requested level, and no description of an adequate course of conservative care modalities. The patient was seen in office on XXXX, complaining of low back pain. The patient had been taking XX, XX, and XX, and was participating in home exercises. The patient denied numbness, weakness, or burning sensations to any body parts. On examination, the patient was able to ambulate without assistance. There was limited range of motion in the low back, with radiating pain to the buttock, thigh, and leg bilaterally. Straight leg raise was positive bilaterally. There was no evidence of focal neurological deficits. The treatment plan included again recommending the lumbar epidural steroid injection. The provider noted that the patient had failed physical therapy, and injection was recommended to reduce inflammation and enhance participation in active therapeutic modalities.

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

According to the Official Disability Guidelines, criteria for lumbar epidural steroid injections includes evidence of nerve root compression confirmed by imaging as well as positive physical examination findings, such as diminished motor strength or diminished sensation correlating with the requested level. Patient should also have failed nonoperative treatment modalities. In this case, the request was previously denied due to a lack of conservative care modalities, as well as a lack of clear radiculopathy on examination. Although the provider noted that the patient had failed physical therapy, there was still no description of sensory changes, motor strength changes, or reflex abnormalities, or other neurological deficits corresponding with nerve root compression at the requested level. Given that guidelines require objective findings as mentioned above, the

request is not consistent with guidelines, and is not supported. Therefore, lumbar epidural steroid injection at L5-S1 is not medically necessary, and the prior determination is upheld.

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