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DATE NOTICE SENT TO ALL PARTIES: 5/21/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of a lumbar ESI.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a lumbar ESI.

PATIENT CLINICAL HISTORY [SUMMARY]:
This patient is a XXXX who sustained an industrial injury on XXXX. The mechanism of injury was described as XXXX, with acute onset of sharp low back pain. A review of records documented conservative treatment to include physical therapy, over-the-counter medication, ice, and activity modification. The XXXX lumbar spine MRI impression documented broad-based diffuse bulging centrally and to the right at L4/5 with right paracentral small disc extrusion causing compression of the L4 nerve root bilaterally, particularly on the right at the neural foramina level. The spinal canal was upper limits of normal. There was bilateral neuroforaminal narrowing due to facet joint hypertrophy, along with early disc desiccation. There was broad-based disc bulging centrally and to the right at the L3/4 level with annular tear and slight compression of the L3 nerve root bilaterally, particularly on the right at the neural foramina level with bilateral neuroforaminal narrowing due to facet joint hypertrophy and desiccation. The XXXX neurosurgical consult report cited complaints of constant grade 6/10 low back and gluteal pain radiating to the thighs, knees, and feet, right greater than left. XXXX reported associated intermittent numbness and tingling in the posterior right leg to the calf. XXXX had completed 24 therapy sessions with some pain relief. XXXX was given a steroid dose pack which really helped XXXX pain. XXXX was currently working modified duty. Lumbar spine exam documented normal range of motion with tenderness to palpation over the central L4 area. Gait was normal. Lower extremity neurologic exam documented 2+ and symmetrical deep tendon reflexes, 5/5 strength, and decreased sensation over the L5 dermatome. MRI was reviewed and showed an L4/5 broad-based diffuse bulging central and to the right, and paracentral small disc extrusion causing L4 nerve root compression. The

diagnosis included low back pain, lumbar radiculopathy, and prolapse lumbar intervertebral disc. The treatment plan recommended a right L4/5 epidural steroid injection. The XXXX utilization review non-certified the request for lumbar epidural steroid injection. The rationale stated that there were no imaging studies/electrodiagnostic results submitted for review, and the request was non-specific and did not indicate the level/laterality being requested. The XXXX utilization review upheld the denial of the request for lumbar epidural steroid injection. The submitted records indicated that the patient had been recommended for an L4/5 epidural steroid injection on the right. However, the rationale stated that there were no imaging studies/electrodiagnostic results submitted for review.

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

The Official Disability Guidelines (ODG) support the use of epidural steroid injections as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. Criteria include radiculopathy (due to herniated nucleus pulposus) documented with objective physical exam findings and corroborated by imaging studies and/or electrodiagnostic studies. The patient should have been initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, muscle relaxants, and neuropathic drugs).

This patient presents with persistent constant moderate low back pain radiating into the bilateral lower extremities, right greater than left, with associated right lower extremity numbness and tingling. Pain precludes return to work full duty. Clinical exam has documented sensory deficit corroborated by the submitted imaging evidence of nerve root compression at the L4/5 level. Reasonable conservative treatment has been attempted for up to 3 months, including oral steroids, over-the-counter medications, activity modification, and physical therapy, without sustained relief. Records indicated that injection was being requested on the right at L4/5. Guideline criteria have been met for epidural steroid injection at this time. Therefore, this request for lumbar ESI is medically necessary.

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
- ☐ AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)