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Notice of Independent Review Decision

DATE OF REVIEW: March 13, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left transforaminal lumbar epidural with selective nerve root block.

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

M.D., Board Certified in Physical Medicine and Rehabilitation with Sub-specialty Certification in Pain Medicine.

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)

I have determined that the requested left transforaminal lumbar epidural with selective nerve root block is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury on xx/xx/xx and was diagnosed with unstable L4-5 spondylolisthesis and lumbar radiculopathy. His past treatments were noted to include medications and surgery. On 12/17/14, magnetic resonance imaging (MRI) of the lumbar spine demonstrated disc bulge at L1-2, with no central canal or foraminal stenosis. At L2-3, there was a mild disc bulge, facet arthropathy, mild central canal stenosis and ligamentum flavum measured 7 mm. There was no foraminal stenosis at L2-3. At L3-4, there was no disc herniation, canal or foraminal stenosis. At L4-5, the MRI report noted facet arthropathy, no foraminal stenosis, and mild central canal stenosis. At L5-S1, there was a small central disc

protrusion measuring 12 x 9 x 11 mm, no central canal stenosis, and slight narrowing of the left foramen. A request has been submitted for left transforaminal lumbar epidural with selective nerve root block.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the initial denial indicated that the ODG requires radiculopathy due to herniated nucleus pulposus, but not spinal stenosis, and objective findings on examination that corroborate with imaging studies. Per the URA, the patient's physical examination reveals some signs of radiculopathy on clinical examination, but on the right side, not the left. The URA noted that the request is for a left-sided epidural steroid injection, which does not correlate with the right-sided findings. On appeal, the URA noted that there is evidence of an L5 radiculopathy on the right, but the MRI at the L4-5 level shows no disc herniation or foraminal stenosis.

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 as a possible option for short-term treatment for radicular pain to facilitate therapeutic activities when radiculopathy is documented on physical examination and corroborated by imaging and/or electrodiagnostic studies, after the failure of conservative care. The clinical documentation submitted for review does provide evidence of radiculopathy at L5 on the right side. However, the request is for the left side. Additionally, the MRI at the level L4-5 shows no disc herniation or foraminal stenosis. Moreover, there is no documentation of failed conservative care to include physical therapy. Given the above information, the request is not supported by the guidelines. All told, the requested left transforaminal lumbar epidural with selective nerve root block is not medically necessary.

Therefore, I have determined the requested left transforaminal lumbar epidural with selective nerve root block is not medically necessary for treatment of the patient's medical condition.

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 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**
- ☐ **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)**