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An Independent Review Organization

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar epidural steroid injection at L5-S1 diagnostic, under fluoroscopy with sedation

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

REVIEW OUTCOME:

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

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

PATIENT CLINICAL HISTORY [SUMMARY]: This case involves a now XXXX with a history of an occupational claim from XXXX. The mechanism of injury is detailed as the patient was XXXX injuring the low back. An MRI of the lumbar spine on XXXX, documented mild to moderate posterior disc narrowing with disc dislocation, facet arthropathy, 1-2 mm broad-based left posterior lateral (foraminal) disc bulge or annular redundancy, and no central neuroforaminal stenosis at L5-S1 level. An electrodiagnostic report on XXXX, documented evidence of left acute L5 radiculopathy. The consultation note on XXXX, documented the patient complained of left lower extremity pain and low back pain. The patient has had physical therapy and medication management with continued symptomology. The patient was not working full duty. On physical examination, heel and toe walking was poor on the left side, the patient had positive straight leg raise on the left, and the patient had decreased dermatomal sensation in the L5-S1 distribution. The treatment plan included a lumbar epidural steroid injection at the L5-S1 level under fluoroscopic guidance with sedation as the patient has needle phobia and a follow-up for reevaluation in 3 weeks.

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

According to the official disability guidelines, there should be evidence of a 50-70% pain relief for at least 6-8 weeks to support repeat epidural steroid injections. In this case, it was indicated the patient had low back pain that radiated to the left lower extremity. On physical examination, the patient has poor heel and toe walking on the left side, a positive straight leg raise on the left, and decreased dermatomal sensation in L5-S1 distribution. This request was previously denied

given the patient previously had injections without relief. The submitted documentation did not provide exceptional factors to support repeat epidural steroid injections given the prior epidural injections did not provide at least a 50-70% pain relief for 6-8 weeks, there was no documentation of a decreased in pain medication usage, and there was no evidence of increased functional improvement with the prior epidural injections for this patient. As such, the medical necessity at this request was not established in accordance with evidence-based guidelines for this patient.

Based on the above documentation, the requested Lumbar epidural steroid injection at L5-S1 diagnostic, under fluoroscopy with sedation is not medically necessary and the review outcome is upheld.

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