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IRO REVIEWER REPORT

Date: 1/16/2018 12:48:38 PM CST

IRO CASE #: XXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Epidural Steroid Injection, Right L5-S1

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:

☐ Overturned	Disagree
☐ Partially Overtuned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a XXXX with a history of an occupational claim from XXXX. The mechanism of injury was detailed as a XXXX. An MRI that was done on XXXX revealed marked facet arthrosis at L4-5. A mild disc bulge at L4-5 and some degeneration of the L5-S1 disc. There was no spinal stenosis, foraminal or lateral recess compromise and no focal disc herniation was seen. Per office visit on XXXX, the patient reported that XXXX fell on XXXX coccyx and XXXX back on the right side having severe low back pain radiating into the right lower extremity. The patient stated the pain in the back was severe, constant, and alleviated by nothing except Medrol dosage pack with muscle relaxant. It was documented that the patient was working light duty. The patient also reported that XXXX had physical therapy and medications without any significant help. The physical examination of lumbar spine revealed the patient had spasm in paravertebral area on the right side at the L5-S1 facet. It was documented that the heel and toe walking were very poor on the right. It was documented that the patient had a positive straight leg raise on the right. The patient had decreased range of motion, significantly restricted in the lumbar flexion, extension and rotation. The patient was recommended a lumbar epidural steroid injection, right L5-S1. There were two requests for authorization that were submitted on XXXX and XXXX. The request for authorization was denied and an appeal was submitted. However, the appeal letter was not submitted for this review or the reason for denial.

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

The California Medical Treatment Utilization Schedule (MTUS) states epidural Glucocorticosteroids injections for chronic low back pain without radicular symptoms are not recommended. They are also not recommended as first- or second-line treatment in individuals with low back pain symptoms that predominate over leg pain. The patient stated XXXX complained of severe low back pain radiating into the right lower extremity. It was documented that the patient had a positive straight leg raise on the right. The patient had decreased range of motion, significantly restricted in the lumbar flexion, extension and rotation. Although the patient had symptoms of radiculopathy the guidelines also states epidural Glucocorticosteroids injections are not recommended as a treatment for any chronic problem.
As such, the request for L5-S1 epidural steroid injection under fluoroscopic guidance is not 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
☐ 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