Applied Independent Review

An Independent Review Organization

Phone Number:
(855) 233-4304

P. O. Box 121144
Arlington, TX 76012
Email:appliedindependentreview@irosolutions.com

Fax Number:
(817) 349-2700

Patient Name:	XX	***Case Number:***	**XXXX**
Review Type:	Preauthorization	***Date of Notice:***	06/28/2018
Coverage Type:	Workers Compensation Nonnet	***IRO Certification No.:***	2146399

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:
XX And Pain Medicine

Description of the service or services in dispute:
L3-L4 TFESI lumbosacral with sedation, under fluoroscopy

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 now XX with a history of an occupational claim from XX. The mechanism of injury was detailed as a XX XX XX. The current diagnoses are documented as spinal stenosis, lumbar radiculopathy, and low back pain. The patient underwent a CT scan of the lumbar spine on XX. At the L3-L4 level there was moderate to severe canal stenosis moderate facet and ligamentous hypertrophy with a broadbased posterior disc bulge resulting in moderate to severe canal stenosis. In the clinical note dated XX, it was noted that the patient had tried and failed physical therapy, injection therapy, and medication management. The patient noted aching in the thighs and legs with standing and walking. The patient had increased lower extremity edema. The patient rated his pain to be a 7/10 in severity with and without medication use. Upon physical examination, it was noted that the lumbar spine was tender to palpation. Range of motion was limited with flexion and extension. Pain was reproduced with facet loading maneuvers. Muscle strength was 5/5 to the lower extremities. Straight leg raise test was positive. Sensation was intact. The treatment plan included for the patient undergo a transforaminal epidural steroid injection bilaterally at L3-L4.

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Notice of Independent Review Decision

Case Number: **XXXX** ***Date of Notice:*** 06/28/2018

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

According to Official Disability Guidelines, a lumbar epidural steroid injection is recommended for short-term pain relief when there is objective findings on examination of lumbar radiculopathy that is corroborated by imaging studies following the failure of conservative care. It was reported that the patient had failed conservative care that involved physical therapy and use of oral medications. However, according to the diagnostic imaging studies of the lumbar spine, the patient had moderate facet and ligamentous hypertrophy with a broad-based posterior disc bulge that resulted in moderate to severe canal stenosis. There is no indication of the patient having foraminal stenosis at this level. Furthermore, there was a lack of documentation regarding physical examination findings of radiculopathy. The patient had 5/5 strength and sensation was intact to the lower extremities. Epidural steroid injections are not recommended for a spinal canal narrowing. As such, the request for L3-L4 TFESI lumbosacral with sedation, under fluoroscopy 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)