Parker Healthcare Management Organization, Inc.

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DATE OF REVIEW: JUNE 26, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed left L1-L2 transforaminal epidural steroid injection (64483)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

REVIEW OUTCOME

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

☐ Upheld (Agree)

XX Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
M54.5	64483		Prosp	1			XX	XX	Overturned

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XX who was injured on XX, when XX. The claimant was diagnosed with low back pain, left hip pain, and an L1-L3 disc herniation. An evaluation on XX, documented a prior epidural steroid injection had been performed at L1-L2 on XX, with 70% pain relief for over six weeks. There was improved left hip and leg symptoms for a few months. An L1-L2 epidural steroid injection was recommended on the left. Electrodiagnostic testing on XX, documented active, chronic L1-L2 radiculopathy on the left. An MRI on XX, documented left foraminal herniated disc at L1-L2 with mass effect on the left L1 nerve root. There was prior physical therapy, TENS use, massage, and medication. An MR arthrogram of the left hip was performed on XX, which documented a labral tear and early osteoarthritis. Medications included XX and XX. The physical examination documented tenderness around the L1-S1 region. Facet loading was positive. There were intact reflexes. There was 4/5 strength on the left in the quadriceps and

hamstrings. Reflexes were symmetric.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:
The previous non-certification was provided due to lack of documentation of improvement and again due to lack of full exhaustion of lower levels of care. An evaluation in XX was provided. Records reflect prior failure of lower levels of care including physical therapy, oral medications, activity modification, TENS use, and injection. There is objective improvement noted with prior injection to include 70% for over six weeks with gradual recurrence of symptoms from a XX injection. There are physical examination findings and testing to support radiculopathy at L1-L2 with corroboration on imaging. Therefore, medical necessity has been established for the left L1-L2 transforaminal epidural steroid injection.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES