AccuReview

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[Date notice sent to all parties]: June 25, 2018, Amended July 4, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar transforaminal epidural steroid injection bilateral L5-S1 (#2) 64483

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board certified in Anesthesiologist with over 16 years of experience.

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
XX: UR performed by XX MD. Reason for denial: From review of the previous treatments, appears a lumbar ESI was performed in the past, but as there's no indication a result of that ESI, there is not sufficient documentation rationale for TFLESI B/L L5-S1 fluoroscopy guided 64483-50, thus the request not approved.

XX UR performed by XX MD. Reason for denial: The MRI showed right L5 root impingement due to L4/L5 disc so this would support doing a right L4/L5 TFE based on a compilation of examination and MRI findings. However, there is no such pathology at the L5/S1 level so there is no support for ESI at this level.

XX: Office Visit dictated by XX, MD. CC: constant daily pain, 9/10 and WC has assigned 5% disability for neck and apparently 5% for back complaints. ROS: positive for chronic back pain and neck, arm pain. Current Medications: XX, XX, XX, XX, XX, XX, XX, XX/XX. PE: Neck: C7 area, ROM is decreased with flexion, extension, and rotation in either direction. DX: 723.4 M50.12 Cervical radiculitis. Refill XX and continue pain management efforts to gain ESI trial.

XX: Office Visit dictated by XX MD. CC: constant lumbar and cervical spine pain 7/10 with both legs intermittently becoming numb and reported pain and numbness to the left arm with positional changes. PE: MSK: cane dependent ambulation, Lumbar – pain at 15 flexion, 5 extension, Neck-tender paraspinous L>>R, moderate lower cervical midline. DX: cervical radiculitis, low back pain. Plan: continue XX and CPMP, seeking efforts for advancing.

XX: MR Lumbar Spine W/O Contrast dictated by XX, MD. Impression: Lower lumbar DDD and facet arthropathy, Moderate effacement of the left L5-S1 lateral recess with mass effect upon the left S1 nerve root and mild effacement of the right L4-L5 lateral recess with mild displacement of the right L5 nerve root, and moderate bilateral L4-5 and moderate left and mild right L5-S1 foraminal stenosis.

XX: Procedure Note dictated by XX, MD. Impression: Other intervertebral disc displacement, lumbosacral region, radiculopathy, lumbar region, radiculopathy lumbosacral region.

XX: UR performed by XX MD. Reason for denial: In this case, the claimant has complaints of lower back pain radiating into lower extremity. The claimant underwent a lumbar ESI on XX. There is no documentation of 70% improvement in pain, but no indication of the pain lasting at least 68 weeks, as recommended by evidence-based guidelines. Hence, medical necessity of this request is non-certified.

XX: Office Visit dictated by XX, MD. CC: back and neck pain. Claimant is here for lower back pain and is currently in CPMP and received 2 back injections and feels like XX pain is improved in the back 70% since but is now gone. The numbness is now gone in the legs and XX is currently working. XX stated XX pain is now worse in the neck and has been getting frequent headaches. XX has BL R>L occipital area hyperthesia. PE: Neck: midline and paraspinous tenderness, there is L S/I and lower lumbar paraspinous tenderness to palpation. ROM limited with extension to 5, flexion to 15, left lateral bending to 10, and right lateral bending to 5. + left SLR. DX: low back pain, neck pain. RX: XX 50mg x 7 days. Plan: continue CPMP, goal would be taper to DC pain management of dangerous/addictive medications for ESI management options in 6 months.

XX UR performed by XX MD. Reason for denial: The requested second bilateral L5-S1 transforaminal ESI are not approved because this request fails to satisfy ODG guidelines criteria which requires at least 50% sustained improvement for a period of 6-8 weeks post-procedure. The submitted available documentation dated XX stated 70% improvement is noted post the initial spinal injection procedure dated XX, however, there is no indication of the duration of therapeutic benefits from first bilateral L5-S1 transforaminal ESI.

XX: Established Patient Encounter dictated by XX, PA-C. PE: SLR right positive at 50, uses cane to ambulate and limping, slow gait and uncomfortable while sitting. Gluteal tenderness, greater trochanteric tenderness, paravertebral muscle spasms, SI joint tenderness, midline tenderness, decreased ROM with increased pain on exertion, positive lasegue/Patrick's test/pelvic rock. Plan: XX chronic cervical and low back pain with radiculopathy, S/P LESI #1 reporting 70% relief. Reports improvement in activity and functionally. Injection therapy was denied as WC carrier would like a reevaluation at the 6-8-week mark. Claimant reported opioid medications allows 50-60% in performance of ADLs, refill XX, decrease XX and continue OTC stool softeners.

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

The previous adverse determinations are upheld and agreed upon. After reviewing the medical records and documentation provided, and considering the peer-reviewed guidelines, the request is non-certified. The MRI showed right L5 root impingement due to L4-L5 disc, so this would support doing a right L4/L5 TFE based on a compilation of examination and MRI findings. However, there is no such pathology at the L5/S1 level so there is no support for ESI at this level. Additionally, there must be demonstration of failure of conservative therapy which has not been demonstrated. As previously stated in the past UR denials, the improvement of 70% improvement is indicated, however, there is no documentation that this was sustained over a 6-8-week period after the epidural steroid injection. After reviewing the medical records and documentation provided, there is no indication that the request is medically necessary at this time. Therefore, this request for Lumbar transforaminal epidural steroid injection bilateral L5-S1 (#2) XX is non-certified.

Per ODG: XX

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 JUDGEMENT, 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)**