

True Decisions Inc.

An Independent Review Organization

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Right S1 ESI

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 year-old XXXX with a history of an occupational claim from XXXX. The mechanism of injury is detailed as the patient was working as a XXXX, resulting in the patient XXXX whereupon injured XXXX back, shoulder, groin and abdomen. Previously, the patient received authorization to undergo a right S1 transforaminal fluoroscopically guided epidural steroid injection. The injection was completed on XXXX with the patient under monitored anesthesia. The Peer Review Report dated XXXX identify the patient had undergone MRI of the lumbar spine on XXXX, although the official report was not provided for review. The results reportedly showed multilevel disc protrusions and a 3.5 mm right disc protrusion at L5-S1 with moderate facet arthrosis. There was indentation of the thecal sac as result of the disc protrusion which was also noted to contact the bilateral L5 nerve roots, on the right greater than the left. In addition, it was noted that the patient had undergone multiple sessions of chiropractic therapy and 9 sessions of physical therapy during XXXX. Additional chiropractic services were completed in XXXX. The patient also reportedly underwent electromyography of the lower extremities on XXXX which revealed S1 radiculopathy on the right. The patient was seen on XXXX with a chief complaint of pain rated at 3/10. The patient was continuing with XX and XX medication and admitted that with XXXX medication, XXXX was still unable to complete all of XXXX daily activities without disabling pain and the need for immediate rest. XXXX also had a hard time standing and walking greater than 15 minutes without having to sit and rest before XXXX low back pain and right leg pain went away. On examination, the patient had elevated blood pressure reading of XXXX. XXXX had tenderness palpation at the lumbar level at L5-S1 on the right with forward flexion painful at 30° and extension at 10°. Manual motor testing was 5/5 in the lower extremities with sensation to light touch and sharp intact. Straight leg raise testing was normal with the patient also having a normal gait and station albeit with pain. Deep tendon reflexes were 2+/4 at the patella and the Achilles bilaterally. There is reference to the patient having MRI evidence of post lumpectomy changes with right lateral disc protrusion causing severe foraminal narrowing. The physician also made reference to the results from the electromyography showing the right S1 radiculopathy. The current diagnoses were documented as a right lumbar radiculopathy, post lobectomy syndrome and lumbar stenosis. The treatment plan was for the

patient to undergo a repeat injection. XXXX had reportedly received 50% relief of symptoms from XXXX most recent epidural steroid injection. The request was denied on XXXX the patient had a failure to return to work, report having disabling pain complaints and difficulty performing standing and walking tasks. There was also continued reliance on a variety of opioid and non-opioid agents to include XX, XX, XX and XX as well as XX taken together. The request was again denied on XXXX with the rationale also stating that despite 50% pain relief, the patient did not have a reduction in the use of medications. The medications XXXX was taking were still unable to relieve XXXX pain. There was failure to show significant functional improvement and medication reduction as required by the guidelines. This request is an appeal for right S1 epidural steroid injection.

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

Regarding the request for right S1 epidural steroid injection (ESI), this request is not supported. The official disability guidelines and stated that in order to meet the criteria for a repeat injection, the patient does have documented evidence of at least 50–70% pain relief for at least 6–8 weeks. In addition, there must be documented evidence of a decreased need for pain relieving medications and functional response. The patient's response to the most recent epidural steroid injection from XXXX reduced XXXX pain by 50%. However, by XXXX, the patient's pain level was still significant and was unrelieved even with the combined use of multiple pain-relieving medications to include narcotics and nonsteroidal anti-inflammatory drugs. Given that the patient did not have documented evidence of at least 6–8 weeks of 50–70% pain relief and evidence of a reduced need for pain relieving medications, nor was there evidence of improved functionality, the patient did not meet criteria for repeating the epidural steroid injection.

As such, in accordance with the previous denial, the request for right S1 ESI 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

Official Disability Guidelines (ODG), Treatment Index, 15th Edition (web), 2017, Low Back Chapter, Epidural steroid injections (ESIs), therapeutic.