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Notice of Independent Review Decision

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

X

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

X

REVIEW OUTCOME

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)

I have determined that X is not medically necessary for treatment of this member's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

This case concerns a X who has requested authorization and coverage for X. The Carrier denied this request on the basis that these services are not medically necessary for treatment of the member's condition.

A review of the progress note dated X indicated that the member has a 10 year history of lifting heavy weight over 50 pounds (lbs.) working for United Parcel Service (UPS). It noted that the member was lifting an object over X head and X was forced backwards in the truck It indicated that the mechanism of injury included flexion followed by extension and side bending. It noted that the member has undergone X, rehabilitative and medical treatment options. It indicated that the member has returned to work light duty however the pain has persisted and the member feels weak and unstable when lifting heavy objects. It noted that magnetic resonance imaging from X was remarkable for a posterior disk herniation at lumbar (L)5 to sacral (S)1, smaller herniated disk at L4 to L5 and another disk herniation at L2 to L3 with a disk bulge/displacement at L3 to L4 consistent with annular disk tear. It indicated that the member's back pain is worse with coughing, sneezing and lifting. It noted that the member has gained over 15 lbs. due to inactivity from this injury. It indicated that the member admits to sleep loss and mood irritability and is under a psychiatrist care. It noted that the member developed gastritis and was told to stop the non-steroidal anti-inflammatory drugs (NSAIDS). It indicated that a X would help hasten the member's recovery. The note describes that there is positive straight leg raise test (SLR) and decreased pinprick in the L5 distribution with trigger points in the lumbar spine. The note does not report any needle phobia or anxiety condition.

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

The Maximus physician consultant indicated that Medical Treatment Utilization Schedule (MTUS) guidelines note an X is recommended as an option for treatment of acute or subacute radicular pain syndromes. Epidural glucocorticosteroid injections are not recommended for treatment of acute, subacute, or chronic low back pain in the absence of significant radicular symptoms. They are also not recommended as first or second-line treatment in individuals with lower back pain (LBP) symptoms that predominate over leg pain. They are not recommended as treatment for any chronic problem per MTUS. The National Imaging Association (NIA) guideline notes X is supported for pain causing functional disability in setting of failed conservative treatment.

The Maximus physician consultant noted that one group reported X may provide short term benefit for radicular pain in cases of nerve root impingement that has failed conservative treatment. The presence of radicular pain should be confirmed based on physical examination findings (Manchikanti, 2021). Another study similarly reported X may provide short term benefit for radicular pain in cases of nerve root impingement that has failed conservative treatment. The presence of radicular pain should be confirmed based on physical examination findings (De Bruijn, 2021).

The Maximus physician consultant indicated that a review of the record indicates that the member has been diagnosed with lumbar radiculopathy. In this case the records reflect low back pain and does demonstrate findings on examination of a dermatomal distribution of radiculopathy in support of X. However, there is no documented needle phobia or anxiety condition with corroborated severity to support need for sedation. As such the medical necessity of the treatment of X is not supported.

Therefore, the requested X is not medically necessary for the treatment of the member's condition.

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 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**

☐ **TMF SCREENING CRITERIA MANUAL**

☒ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE**

Manchikanti L, et al. Epidural Injections for Lumbar Radiculopathy and Spinal Stenosis: A Comparative Systematic Review and Meta-Analysis. *Pain Physician*. 2016 Mar;19(3):E365-410.

Manchikanti L, et al. Epidural Injections for Lumbar Radiculopathy or Sciatica: A Comparative Systematic Review and Meta-Analysis of Cochrane Review. *Pain Physician.* 2021 Aug;24(5):E539-E554.

de Bruijn TM, et al. Clinical Relevance of Epidural Steroid Injections on Lumbosacral Radicular Syndrome-related Synptoms: Systematic Review and Meta-Analysis. *Clin J Pain.* 2021 Jul 1;37(7):524-537.

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**