

**DATE OF REVIEW: 8/10/07****IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Lumbar epidural steroid injection.

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

This case was reviewed by a board certified anesthesiologist on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal.

**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>Primary Dx Code</i> | <i>HCPCS/NDC</i> | <i>Units</i> | <i>Begin/End Date</i> | <i>Type Review</i> | <i>Amt Billed</i> | <i>Date of Injury</i> | <i>DWC Claim #</i> | <i>Uphold / Overturned</i> |
|------------------------|------------------|--------------|-----------------------|--------------------|-------------------|-----------------------|--------------------|----------------------------|
| 724.2                  | 62311            | 1            |                       | Prospective        |                   | xx/xx/xx              | xxxxxxx            | Upheld                     |

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for Independent Review by an Independent Review Organization forms – 7/31/07
2. Determination Notices – 7/5/07, 7/12/07
3. Records and Correspondence from Consultants – 1/31/07-6/28/07
4. Records and Correspondence from neurological – 12/18/06
5. Records and Correspondence from, MD – 12/2/05
6. Records and Correspondence from – 6/13/07

**PATIENT CLINICAL HISTORY:**

This case concerns an adult male who sustained a work related injury on xx/xx/xx. Records indicate that he sustained injury when he fell. Records provide no further specifics regarding the circumstances of this injury. Diagnoses have included chronic lumbar radiculopathy and back pain. Evaluation and treatment for this injury has included injections, electrophysiological studies, and MRIs.

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

This case concerns an adult male who sustained a work related injury on xx/xx/xx. His diagnoses to date include chronic lumbar radiculopathy and back pain. An MRI obtained in xx/xx/xx demonstrated severe disc bulging at L5-S1 associated with epidural enhancement in the left S1 lateral recess. EMG studies have demonstrated lumbar radiculopathy involving the left S1 nerve root. The documentation has indicated he has received 2 epidural steroid injections with reported modest results in pain control. He

continues with back pain and was recommended to receive a 3<sup>rd</sup> epidural steroid injection.

There was no documentation provided necessitating additional epidural steroid injection therapy at this time. There was no documentation of conservative modalities (medical therapy, physical therapy) used for the treatment of his back pain. In addition, there was no documented neurosurgical evaluation to determine if he has a surgically correctable disc problem. The requested additional epidural steroid injection does not meet the Official Disability Guidelines. He needs a trial of conservative therapy for his ongoing back condition prior to consideration for additional injections therapy

**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)