

IRO America Inc.

DATE OF REVIEW: March 15, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar epidural steroid injections at L3/4, L4/5. L5/S1

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

Board Certified Orthopedic Surgeon

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

IRO request

Lumbar spine MRI, 09/15/06

Office note, Dr., 11/14/06

Office notes, Dr., 12/14/06, 01/03/07 and 01/22/07

Office note, Dr., 01/24/07

Utilization review, Dr., 01/30/07

pre authorization decision 02/01/07, 02/15/07

Utilization review, 02/13/07

Prospective review Dr., 02/26/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This female injured her low back when lifting a large trash can. A MRI of the lumbar spine demonstrated degenerative disc disease with prominent midline disc bulge at L5-S1 but without thecal sac or nerve root compression. The claimant treated with Dr. following her injury.

Dr. evaluated the claimant for low back pain with radiation to the left lower extremity. The claimant had mild tenderness of the lumbar paravertebral area with muscle spasm. Reflexes were normal and there was no evidence of radicular pain. The diagnosis was lumbar sprain, symptomatic.

The claimant continued to treat with Dr. and on 12/14/06 was noted to still have intermittent pain in her back. She had normal strength with no evidence of sciatic irritation on straight leg raise. The diagnosis was soft tissue injury of the lumbar spine without radiculopathy. The claimant had a paraspinal block without benefit. The claimant was referred to Dr. for consideration of epidural steroid injections. He evaluated the claimant on 01/24/07 for low back pain radiating into the left hip and groin and sometimes into the thigh. There was minimal radiation of pain into the lower extremities. Motor/sensory exam was intact and reflexes were 2 plus. The claimant had some tenderness over left lower lumbar facet area with positive Faber sign. Straight leg raise was negative. The physician recommended lumbar epidural steroid injection times three. The injections were denied twice on peer review.

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

The disputed service is Lumbar epidural steroid injections at L3/4, L4/5. L5/S1. The Reviewer agrees with the denial of the lumbar epidural steroid injections.

Based on review of the records provided, the epidural steroid injections are not recommended. The claimant has been treating for low back pain without radicular complaints. She has no evidence of nerve root compression on MRI. There are no examination findings compatible with radicular pathology. Epidural steroid injections may provide short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus. However, the medical literature does not support the efficacy of epidural steroid injection in the absence of radicular symptoms. The information provided regarding this claimant does not support the use of epidural steroid injections.

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)