

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.

DATE OF REVIEW: March 27, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar epidural steroid injections

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

Board Certified, Neurology; Diplomate, American Board of Pain Medicine

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Carrier include:

- Texas Department of Insurance, 03/14/07
- 02/12/03
- M.D., 10/26/04, 11/01/05, 12/15/05, 03/14/06
- M.D., 01/19/05, 02/09/05, 04/06/05, 05/04/05, 05/18/05, 07/06/05, 03/13/06, 09/13/06, 10/18/06, 01/15/07, 02/19/07
- 09/28/05
- M.D., 11/18/05
- M.D., 11/30/06
- M.D., 12/08/06
- , M.D., 03/14/07

Medical records from the Requestor include:

- 02/12/03
- M.D., 10/26/04
- M.D., 01/19/05, 02/09/05, 03/09/05, 04/06/05, 05/04/05, 05/18/05, 07/06/05, 03/13/06, 09/13/06, 10/18/06, 01/15/07, 02/19/07

March 27, 2007

Page 2 of 3

- M.D., 11/30/06

PATIENT CLINICAL HISTORY:

The patient reportedly tripped on the above date with resultant low back and left leg pain. She saw M.D. and M.D. She did not respond to physical therapy. She received temporary improvement with medication such as Ultram, Hydrocodone, and Effexor. Neurological examination has been normal.

MRI of the lumbar spine has been unremarkable except for facet arthropathy at L4-5 on February 12, 2003.

The patient also injured her back when she was rear-ended. She had side effects with Neurontin. She was also diagnosed with complex regional pain syndrome type I by Dr. on April 6, 2005. Topamax caused blurred vision.

The patient complained of some new thigh pain with Dr.. The patient asked Dr. on if she could apply for disability since she could not do her job.

The patient described to Dr. on November 30, 2006 that she had episodes of falling and losing her balance. Physical therapy did not help. Dr. noted tenderness over the left sacroiliac joint for the first time.

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

The request for epidural steroids which has been denied per the initial review is upheld. Epidural steroid injections, according to the ODG Treatment in Workers' Compensation 2006, are recommended as an option prior to surgery where there are radicular signs. The patient has radicular symptoms but no signs. She has had no weakness or reflex change. She has no objective sensory changes. There is no evidence of a herniated disc by MRI imaging times two. These are recommended for short term relief as a means of avoiding surgery and facilitating return to activity. The patient is already working full time. It has also been almost five years since her original injury. It is unlikely that a single epidural steroid at this point in time, which affords temporary relief, would be of any benefit to the patient. She does not meet criteria for the use of epidural steroid injection, i.e. radiculopathy has not been documented by signs, and surgery/discectomy is not an option based on her clinical presentation.

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)