

- **Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 4/26/07, 1 page.**
- **Company Request for Independent Review Organization dated 4/25/07, 4 pages.**
- **Request for a Review by an Independent Review Organization dated 4/18/07, 2 pages.**
- **Determination Notification Letter dated 4/25/07, 4/13/07, 4 pages.**
- **Letter dated 4/30/07, 1 page.**
- **Pre-Authorization Request dated 4/10/07, 1 page.**
- **Symptom Questionnaire/General Exam Note dated 4/10/07, 2 pages.**
- **Follow-Up Visit dated 4/10/07, 1 page.**
- **Initial Evaluation Report 3 pages.**

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

Patient's age:

Gender: Male

Date of Injury:

Mechanism of Injury: Secondary to fall.

Diagnoses:

1. Lumbar disc bulge.
2. Lumbago.

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

A review of the information submitted indicated that this claimant had an accepted work related injury involving the lumbar spine. He was reportedly knocked off an 18-wheeler trailer when another truck struck his vehicle. The claimant experienced back pain immediately upon the accident. The claimant described his pain as electric like, numbing, and burning, worse in the morning and at night. The patient described that his pain was radiating from the back to his legs, aggravated with standing, bending, and twisting. The patient had completed conservative treatment consisting of physical therapy, which rendered some relief. A lumbar MRI was performed on 1/24/07, which reportedly revealed diffuse disc bulging at L5-S1 level with a right-central disc protrusion encroaching on the right nerve foramen and entering nerve root at that level. Objective findings from the initial evaluation report submitted, dated 2/14/07, revealed trigger points present on the left side, lumbar facet joint tenderness left lower side, range of motion on lumbar spine limited, sacroiliac joints non-tender, straight leg raise negative bilaterally, and Fabere and Apley negative bilaterally. The sensory examination in the lower extremities was normal bilaterally, and motor examination was normal on the right and normal on the left side except L2-S1. Reportedly, from the peer review determinations, the claimant had previously undertaken a lumbar epidural steroid injection performed on 3/20/07. A follow-up note submitted, dated 4/10/07, revealed that this patient continued to have severe pain in the lower back rated 7 on a scale from 1 to 10 with restricted movement. The medication

management consisted of Zanaflex 4 mg one p.o. b.i.d., Norco 10 mg one p.o. q. 10h., and Lidoderm patches. In the opinion of this reviewer, after evaluating the submitted documents, the denial should be upheld for a lumbar epidural steroid injection #2 because of lack of available relevant clinical information to support its application. Particularly, there was no information regarding the efficacy following the first lumbar epidural steroid injection, and there was no documentation of decrease in pain, decrease in medication intake, or decrease in functional status. It is opinion of this reviewer that a second lumbar epidural steroid injection would not provide a substantial and sustained decrease in the patient's pain symptoms.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X 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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES. Official Disability Guidelines, Treatment Index, 5th. Edition, 2006/2007. Low Back-Epidural injections.

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

TEXAS GUIDELINES FOR CHRIOPRACTIC QUALITY ASSURANCE AND 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).

Practice Guidelines, 1st Edition (2004), Spinal Diagnostic and Treatment
Procedures (ISIS), Edited by N. Bogduk, M.D.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.