MEDICAL REVIEW OF TEXAS

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Notice of Independent Review Decision

DATE OF REVIEW: NOVEMBER 26, 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
MD, Board Certified in Physical Medicine and Rehabilitation

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

X 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

- Office notes from Dr. [9/6/07, 7/24/07]
- MRI report [6/16/06]
- EMG report [7/23/07]
- Denial letters from Insurance [10/1/07, 10/16/07]
- Records from Evaluators [5/23/07]
- Designated doctor evaluation [, MD 5/23/07] [, MD 11/17/06]
- Treatment records from [2/22/07]
- [10/2/07, 10/8/07]
- MD report [7/23/07]

PATIENT CLINICAL HISTORY [SUMMARY]:

Records reviewed indicate this individual was injured in 2006, followed by Dr. and chiropractic physician. He received conservative care, recommended lumbar ESIs, denied by the carrier, and had EMG proving L4 radiculopathy. MRI on March 2, 2007, showed focal disc protrusion at L4-L5 and herniation at L5-S1, facet arthropathy, and narrowing of the intervertebral foramina at L5-S1 and narrowing of the lateral recesses at L4-L5 and L5-S1. This is documented in report from designated doctor in May 2007. Second opinion recommended surgical procedure, which was not performed. There were minimal findings of spinal stenosis and DJD.

On May 23, 2007, he was treated at Evaluators and did some form of FCE. His push and pulling work did not meet the minimal demand level of his job. He was awarded a 5% impairment under the DRE Model. Further history indicates he is an worker who is xx years old. While working in the he had a previous EMG, which showed a right radiculopathy in the L4 dermatome. He has a far lateral disc protrusion at L4-L5 level, requesting for L4-L5 transforaminal injection on September 6, 2007 per Dr.

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

This individual has proven radiculopathy. As a hardworking individual, he has ongoing radicular pain documented in the records. He has MRI proven disc abnormality consistent with his injury and epidural steroid is the Gold Standard treatment for this particular injury. There are occasions when the ODG guidelines conflict with the more standard literature in terms of frequency, but clearly the ODG guidelines indicates radiculopathy must be present for epidural steroid injections and that previous results should be positive. Both of these hurdles are met. The type and nature of his disc herniation, as well as experience as a physiatrist treating patients for this problem certainly support the need for repeat epidural steroid injections as requested by Dr..

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**
- X **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 – NOT PROVIDED**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- X **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE**
  - * International Spine Intervention Society Guidelines
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**