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DATE OF REVIEW: April 18, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar epidural steroid injection (62310)

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

Diplomate, American Board of Anesthesiology; Diplomate, American Academy of Pain Management

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)

PATIENT CLINICAL HISTORY:

This is a male who sustained a work related injury involving the lumbar spine. The patient was attempting to sit down on a rolling chair which moved out from under him, causing the patient to land flat on his buttocks. The current diagnoses are: 1) Lumbar disc disease with intermittent radicular symptoms. 2) Thoracic facet pain. 3) Somatic dysfunction of the thoracic spine. 4) Trapezius myofascial pain. 5) Intermittent cervical radiculopathy.

Subsequent to the injury a lumbar MRI was performed on August 28, 2006, which revealed

mild spondylosis with bilaterally posterolateral annular tears and a shallow 2-3 mm disc protrusion at the L4-5 level, with mild-to-moderate bilateral neural foraminal narrowing; a disc bulge and annular tear at the L5-S1 level; and a disc bulge at the L3-4 level.

A handwritten EMG/nerve conduction study performed on December 21, 2006 revealed chronic bilateral L5 radiculopathy; no active changes present.

Of note, there are no dates of treatment through the year of 2007. The documentation picks up on January 28, 2008, with a consultation from a pain management physician, D.O. The patient was complaining at that time of low back pain radiating into both lower extremities, left worse than right. The current medication management consists of Tramadol and a muscle relaxant. The physical examination pertaining to the lumbar spine reveals paravertebral hypertonicity from L3 through L5 bilaterally. The consultation report submitted did not provide any information regarding the presence or absence of sensory, motor, or reflex deficit in the lower extremities or any other associated findings indicative of lumbar radiculopathy.

A designated doctor evaluation submitted for review was performed by M.D., on March 24, 2008. In her clinical examination of the lumbar spine, straight leg raising was positive on the right and on the left, causing pain in the back only. The flexion, extension, and lateral bending maneuvers were restricted with pain. The neurological examination revealed no decreased sensory sensation, a normal motor examination, and intact muscle strength in the lower extremities.

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

After a review of the information submitted, it is the opinion of this reviewer that the previous non-authorization for a lumbar epidural steroid injection be upheld because: 1) The available and relevant clinical information revealed there was no presence of significant objective radiculopathy demonstrated on clinical examination, although the patient seems to have subjective complaints indicated of radiculopathy; 2) The radiographic imaging study of a lumbar MRI did not reveal any significant disc herniation, central canal stenosis, or nerve root compression; 3) The patient's EMG/nerve conduction study did not correlate with radiographic imaging studies.

Therefore, the request submitted does not meet the criteria according to the Official Disability Guidelines, Treatment Index, 5th Edition, 2008 (Web), under Lumbar Epidural Steroid Injection, which clearly states that radiculopathy must be documented; objective findings on examination need to be present for unequivocal evidence of radiculopathy.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRO
- 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)**