

# Applied Resolutions LLC

An Independent Review Organization  
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## Notice of Independent Review Decision

**DATE OF REVIEW:** 04/22/08

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

L2-3 lumbar epidural steroid injection.

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

M.D., Board Certified Orthopedic Surgeon  
M.D., Board Certified 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)

Upon independent review the reviewer finds that the requested L2-L3 lumbar epidural steroid injection is not medically necessary

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters 3/13/08, 3/21/08  
ODG Guidelines and Treatment Guidelines  
Exam Notes MD 2008 1/3, 3/5, 3/17  
Exam Notes MD 2007 3/29, 6/14, 9/20  
Exam Notes MD 2006 3/27, 7/27, 11/27  
Exam Notes MD 2005 2/17, 5/12, 11/21  
Exam Notes MD 2004 9/27, 11/8, 11/29, 12/27  
Exam Notes MD 2002 12/9, 2/18  
Exam Notes MD 2001 8/13, 8/30  
Operative Reports 11/23/04, 8/28/01, 2/18/97

Radiology Reports 11/23/04, 9/27/04, 8/28/01, 8/13/01, 12/1/98, 11/12/97, 2/12/98, 7/28/97, 5/19/97, 3/18/97, 9/9/96  
Letters to, MD 2/12/98, 11/13/97, 7/28/97, 5/28/97, 3/17/97, 2/13/97, 12/26/96, 12/9/96, 11/14/96, 10/24/96, 9/26/96, 8/29/96, 7/29/96, 6/24/96, 5/13/96, 2/29/96, 9/14/95  
Myelogram Report 3/6/98  
Return To Work Letter 6/30/97  
Discharge Summary 2/18/97, 2/9/96  
Physician Review Recommendations 3/12/08, 3/21/08  
History and Physical Exam 2/18/97  
Electromyography and Nerve Conduction Studies 1/22/98

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is an injured worker who is a female, with a date of injury of xx/xx/xx when a bundle of papers fell on her, while working . She had a microdiscectomy performed in February 1996 at L5/S1 and in February 1997, Dr. performed an L4/5 and L5/S1 decompression and L5/S1 fusion. She was followed for mechanical back pain. Epidural steroid injections were given off and on until 2002, with improvement. She developed a thymoma in 2003 and underwent chemotherapy. She continued to have back pain. A lumbar epidural steroid injection was given without significant benefit in September 2004. Through 2004, she continued to complain of back pain and radiating leg pain. A CT myelogram showed a far right posterolateral herniation at L2/3. She had reflex and weakness changes compatible with an L5 radiculopathy. Current recommendations are for an L2-L3 epidural steroid injection

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

This patient does not meet the criteria set forth by ODG Guidelines to be considered a compelling candidate for an epidural steroid for the following reasons: While she does have the lesion, it is extremely remote and her complaints are of mid lumbar pain and bilateral hip pain. There was noted to be positive straight leg raising, which of course would not be compatible with an L2/3 disc, and in particular, the Official Disability Guidelines state that epidural steroids are a recommended possible option for short-term treatment of radicular pain, which requires dermatomal distribution to corroborate the findings of radiculopathy and is to be used in conjunction with an active rehabilitation effort. This patient does not meet this criteria based upon the information available in the medical record. It is for this reason the previous adverse determination is upheld.

**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)