



514 N. Locust
Denton, TX. 76201
Off: (940) 239.9049
Fax: (940) 239.0562

Notice of Independent Review Decision

DATE OF REVIEW: 08/11/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Translaminar ESI L5-S1 under fluoro and lumbar x-ray

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

Board Certified in Orthopedic Surgery

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)

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.

Lumbar Translaminar ESI L5-S1 under fluoro - Upheld
Lumbar x-ray - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Operative report (AP and lateral lumbar x-ray, Fluoroscopy, Single shot epidural at L5-S1), , M.D., 07/12/07
- MRI of the lumbar spine, , M.D., 09/24/07
- MRI of the cervical spine, Dr., 09/28/07
- Telephone contact, Dr. and Dr., 10/03/07
- Examination evaluation, Dr., 12/05/07, 01/16/08, 02/13/08, 03/19/08, 06/27/08
- Right L5-S1 translaminar epidural steroid injection, M.D., 02/28/08
- Examination evaluation, Dr., 02/28/08
- EMG report, M.D., 03/07/08, 04/11/08
- MRI of the cervical spine, , M.D., 05/12/08
- Examination evaluation, Dr., 06/10/08
- Intake form, 07/03/08
- Referral form, CPR –, 07/03/08
- Case Summary Report, Workers' Comp Services, 07/08/08, 07/09/08, 07/21/08
- Adverse determination letter, 07/09/08, 07/21/08
- Letter of medical necessity, Dr., 07/10/08
- Notice of assignment of IRO, 07/23/08
- Clinical history sheet, Magnetic Imaging Center (no date)
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient sustained an injury to his low back and neck on xx/xx/xx. It was noted that because of the patient's myasthenia he did not have very good lower body strength and was unable to walk or do any exercises. X-rays were performed and multiple injections were administered. MRI's were also performed on both the cervical and lumbar spine. The patient's latest medications include Zoloft, Lyrica, Valium, Keto/Bac/Cyclo/Lido, Benadryl Allergy, Cymbalta, Ultracet, Promethazine HCL, and Klonopin.

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

Upon independent review, the reviewer finds that previous adverse determination/determination should be upheld.

According to ***ODG Treatment Guidelines***, lumbar ESIs are medically reasonable and necessary when there is evidence on electrodiagnostic studies and MRI consistent with radiculopathy and focal disc herniation, with focal nerve root compromise that correlate with physical examination findings of radiculopathy and subjective complaints of radicular pain. Although this patient

clearly had subjective complaints of pain, he does not have MRI evidence of focal disc herniation, compressing or compromising the right L5 or S1 nerve roots. In fact, the MRI found worse findings on the LEFT (opposite) side. Additionally, the only positive finding on the patient's physical examination, a straight leg raising test at 15 degrees, is indicative of nonphysiologic functional overlay or symptom magnification, rather than any true pathology. The sciatic nerve does not even begin to stretch until 30 degrees on a straight leg raising test. Therefore, a positive test at 15 degrees is not indicative of anything other than functional overlay and symptom magnification. Finally, although the EMG finding allegedly demonstrates L5-S1 radiculopathy, it is termed "chronic and moderate". Additionally, the patient's complaints of global weakness in all four extremities, coupled with his diagnosis of untreated myasthenia gravis, are more likely the source of his current complaints than anything identified on the MRI or related to his work injury. The patient has also gained no significant functional improvement following any of the previous two lumbar ESIs performed by Dr., who consistently and repeatedly documented the claimant's activities of daily living are either "practically 0" or not very good at all.

Therefore, based upon all of the above discussion, as well as ***ODG Treatment Guidelines*** and nationally accepted standards of medical care regarding ESIs, lumbar translaminar L5-S1 ESI under fluoroscopy and x-ray is not medically reasonable or necessary, and is not medically indicated.

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)