

SENT VIA EMAIL OR FAX ON  
Dec/29/2008

# Applied Assessments LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/27/2008

**IRO CASE #:**

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

Epidural Steroid Injection under Fluoroscopic Control w/Epidurogram #2 Back Lumbar

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

Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in 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 SUMMARY**

Most of the history is from Dr. 's letters of 10/23/08 and 11/20/08 appealing the denial of a repeat epidural corticosteroid injection. The person is a xx year old man reportedly injured in xxx/xxxx. He had L3/4 and L4/5 facet injections on 4/18/08 that apparently provided him with significant improvement of his pain. He still had some residual pain that Dr. described as radicular pain. He underwent a single epidural injection by Dr. on 6/20/08 that reportedly provided 50% relief on the pain. Dr. cited an MRI report that showed bilateral L4 root compression. Dr. said it showed bilateral L4 root compression. The only physical examination that I have is from Dr. on 6/6/08. I have Dr. 's procedure note. Dr. wrote that this man did well with prior epidural injections, but did not elaborate. Dr. wrote that this man had radicular symptoms, but did not provide clinical findings of a radiculopathy. In fact, he described symmetrical knee and ankle jerks and 5+ strength in the loser extremities. SLR was negative at 90 degrees. Dr. reported in his note that there were the facet changes, but the disc protrusion at L3/4 and a central one at L4/5, and a bulge at L5/S1 but did not describe any nerve root compression.

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

First, there is no definite evidence of a radiculopathy. Dr. said there is, but Dr. found (per Dr. ) "Lower back pain and bilateral leg pain, left worse than right, S1 by physical examination." The Reviewer does not recall that on the 6/6/08 note cited. The examination of that date did not show any neurological deficit or confirmation of a radiculopathy as required

by the ODG. The Reviewer is also unclear how the pain was found on physical examination, or did his examination show evidence of a S1 radiculopathy? If the latter, how was this related to the L4 root compression on the MRI. One fault of MRIs is that their sensitivity often shows changes that are not causing symptoms. Perhaps other medical records with examinations would confirm the presence of a radiculopathy vs the presence of radicular symptoms. Dr. did comment on this man's description of symptom improvement with the prior ESIs.

He had symptom improvement with the ESI in June, but there is no report of any accompanying physical therapy to maximize its benefit. The ESI is recognized as a temporary solution. Further, there is no justification for ESIs to be used for mechanical back pain.

This man's symptoms and injury are more than xx years old placing it in the chronic pain category. The Reviewer could not determine from the records how long this man was symptom free. The ESI questionnaire is dated 7/2/08, not quite 3 weeks post injection.

Until there is objective material confirming a radiculopathy (which may be in records not provided) and documentation of at least 6-8 weeks of benefit, The Reviewer can not justify setting aside the ODG requirements. Again, this material may be available, but was not provided.

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

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)