

# MEDICAL REVIEW OF TEXAS

[IRO #]

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**DATE OF REVIEW: JANUARY 7, 2008**

**IRO CASE #:**

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

Lumbar ESI L5-S1

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

MD, 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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. – Letters dated 11/16/07, 12/5/07
2. – Peer Review 11/16/07
3. MD – Peer Review 11/30/07
4. “Spine Journal” September, October 2004 – Part of an article entitled “The Affect of Spinal Steroid Injections for Degenerative Disc Disease”
5. – January 2004 – Part of an article on epidural steroid injections
6. “Journal of Surgery” 2006 – Part of an article about epidural steroid injections from pages 1722-1725

7. MD – Evaluation 6/15/04, 7/6/04, 7/21/04, 9/21/04, 10/19/04, 11/2/04, 11/23/04, 1/4/05, 2/8/05, 3/8/05, 3/29/05, 5/10/05, 6/21/05, 7/12/05, 8/23/05, 10/6/05, 11/3/05, 12/1/05, 1/6/06, 2/3/06, 3/10/06, 5/15/06, 5/21/06, 6/16/06, 7/24/06 and a TWCC Form 69 from that date, Evaluation 10/16/06, Letter of Medical Necessity for medications 2/9/07, Evaluation 3/7/07, 6/4/07, 9/24/07 and 11/8/07, Operative reports for 10/8/04 where he performed a lumbar laminectomy and discectomy L5-S1 on the right, Operative report for 4/29/05 where he performed an anterior interbody cage fusion as well as a posterior lateral fusion with pedicle screw fixation and insertion of a bone growth stimulator, Operative report for 4/5/06 where the segmental hardware was removed and a supplemental posterolateral fusion at L5-S1 was performed, and a letter from Dr. dated 11/27/07.
8. Diagnostic Healthcare – A CT scan of the lumbar spine without contrast 2/22/06
9. MRI and Diagnostic – MRI with and without contrast 3/25/05
10. – Evaluation and EMG and nerve conduction studies 6/28/04
11. Diagnostic – MRI of the lumbar spine performed 6/24/04
12. MD – Evaluation 8/3/04, a procedure note for lumbar epidural steroid injection 8/19/04
13. MD – Chest x-ray report from 5/29/05
14. Dr.– (the doctor's first name is illegible in this handwritten medical note) from 3/31/06 which was for medical clearance for surgery
15. Rehabilitation–Rehabilitation and Therapy and Diagnostics – Multiple functional capacity evaluations performed subsequent to this patient's injury
16. MD – Designated doctor evaluation 9/18/06 and follow-up 3/22/07
17. MD – Required medical examination and a TWCC 73 form from 12/14/05 and a required medical examination from 1/30/07
18. MD – Required medical examination and TWCC 73 form from 8/17/04
19. ODG not provided

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This man was lifting boxes while employed as a tool manager at a store. He developed low back pain. He was initially treated with physical therapy. An MRI performed was compatible with a lumbar disc protrusion at L5-S1 on the right. EMG and nerve conduction studies performed 6/28/04 showed right L5-S1 nerve root irritation with mild radiculopathy. At least one epidural steroid injection was performed 8/19/04.

Because of ongoing symptomatology the patient underwent a lumbar laminectomy and discectomy by MD on 10/8/04. Postoperatively he had ongoing low back pain. A repeat MRI of the lumbar spine performed 3/25/05 showed normal lumbar discs at all levels with the exception of L5-S1 where there was a 3 mm right sided disc protrusion and a Grade IV annular tear.

Because of ongoing low back pain the patient was returned to the operating room on 4/29/05 by Dr. where he underwent a 360° fusion at L5-S1. Postoperatively the patient's low back pain persisted despite ongoing treatment with multiple medications and therapy. A repeat CT scan was performed on 2/22/06, which suggested a solid fusion at L5-S1. No other disc herniations were noted. Facet arthropathy was thought to be present at L4-5.

Because of ongoing low back pain, the patient was returned to the operating room on 4/5/06 by Dr. for removal of his posterior segmental hardware and supplemental posterolateral fusion at L5-S1. Despite this surgery the patient's low back pain persisted. He is currently being treated with multiple medications including Ultram, Ambien, Naprosyn, Soma and Lorcet. He has also been given a Medrol Dose Pack. He has had substantial amounts of physical therapy. No treatment provided over the years has alleviated this patient's low back pain. A lumbar epidural steroid injection is now being requested.

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

THIS PATIENT HAS HAD ONGOING LOW BACK PAIN FOR YEARS. HE HAS NEITHER SIGNS NOR SYMPTOMS OF RADICULOPATHY. HE HAS BEEN TREATED WITH SUBSTANTIAL AMOUNTS OF PHYSICAL THERAPY, MULTIPLE MEDICATIONS, AN EPIDURAL STEROID INJECTION AND 3 SURGICAL PROCEDURES. NO TREATMENT PROVIDED HAS RELIEVED HIS SUBJECTIVE COMPLAINTS OF LOW BACK PAIN. RADIOGRAPHICALLY HE HAS A SOLID FUSION AT L5-S1 WITH NO OTHER SIGNIFICANT INTERSPINAL PATHOLOGY AT THAT LEVEL OR ANY OTHER LEVEL TO EXPLAIN HIS DISCOMFORT.

IN THE ABSENCE OF SYMPTOMS OF RADICULOPATHY AND NO OBJECTIVE EVIDENCE OF INTERSPINAL PATHOLOGY THAT WOULD RESPOND TO EPIDURAL STEROID INJECTION, THERE IS NO INDICATION THIS PROCEDURE HAS ANY LIKELIHOOD OF RELIEVING THIS PATIENT'S SUBJECTIVE COMPLAINTS.

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### **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  
\* "CAMPBELL'S OPERATIVE ORTHOPEDICS" 11<sup>TH</sup> EDITION
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)