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Notice of Independent Review Decision

DATE OF REVIEW: 06/17/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat Lumbar Translaminar ESI - #2 L5-S1 Bias to the Left

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

Fellowship Trained in Pain Management
ABA Board Certified in Anesthesiology

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.

Repeat Lumbar Translaminar ESI - #2 L5-S1 Bias to the Left - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Neurological Consultation/EMG-NCV, M.D., 08/24/05
Examination Evaluation, M.D., 11/27/07, 01/08/08, 03/04/08, 04/15/08
Operative Report, Dr. 04/04/08
Nurse Notes, 04/15/08
Outpatient Pre-Authorization Request, 04/22/08
Peer-to-Peer Review with Dr. 04/25/08
Letter of Medical Necessity, Dr. 04/29/08
Adverse Determination Letter, 04/25/08, 05/23/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient injured his lower back while lifting supplies at work. He has undergone epidural steroid injections, partial discectomies and a work hardening program.

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

Dr. documented physical examination evidence of functional overlay, not radiculopathy. A positive straight leg raise at 15 or 25-30 degrees is entirely nonphysiologic and does not demonstrate any valid evidence of radiculopathy, as lumbar nerve roots and sciatic nerve roots do not even begin to stretch until 30 degrees. Therefore, any positive tests at less than 30 degrees is more medically likely than not indicative of functional overlay and symptom exaggeration rather than any true pathology. Given the lack of any current objective evidence of recurrent or residual disc herniation on any MRI studies, coupled with the normal reflex, sensation, and motor examination consistently documented by Dr. there is not a valid indication, therefore, for any ESI's. That lack of objective evidence of recurrent or residual herniation and lack of physical examination evidence of neurologic deficit is even more amplified by the nonphysiologic straight leg raising that resulted. Therefore, in my opinion, this patient is not an appropriate candidate for ESI's. Given the minimal pain reduction following the ESI on 04/04/08 and the patient's essentially unchanged pain complaint and physical examination following that injection, there is, in my opinion, no justification for repeating the ESI. Furthermore, *ODG* treatment guidelines do not support performing ESI in the absence of both objective evidence of disc herniation causing nerve root compression and physical examination, and electrodiagnostic evidence of radiculopathy. Therefore, for all the above reasons, this patient is clearly not an appropriate candidate for repeating the ESI as requested. There is no medical evidence to provide a valid medical indication to perform the injection, nor did the patient receive sufficient response from the injection already performed to justify repeating it. Therefore, repeat translaminal ESI #2 at L5-S1 is not medically reasonable or necessary.

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)