COMPPARTNERS

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION

Notice of Independent Review Decision

DATE OF REVIEW: **3/10/08** **AMENDED:** **3/17/08**

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for epidural steroid injection, L4-5 and L5-S1.

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

Texas Licensed Orthopedic Surgeon.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X 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.

The previously denied request for epidural steroid injection, L4-5 and L5-S1.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- **Confirmation of Receipt of Request for a Review dated 2/29/08.**
- **Request for a Review by an Independent Review dated 2/28/08.**

- **Notice to CompPartners, Inc. dated 3/3/08.**
- **Recertification Request Proposed Procedure dated 2/7/08.**
- **Follow-Up dated 1/30/08, 11/7/07, 9/26/07, 8/7/07, 7/3/07, (unspecified date).**
- **Operative Report dated 6/20/07.**
- **Upper Extremity Electromyography Studies dated 10/29/07.**
- **Electrodiagnostic Results dated 10/29/07.**
- **Lumbar Spine MRI dated 1/11/08, 5/14/07.**
- **Nerve Conduction Studies Results dated 6/4/07.**
- **Service Request dated 2/12/08, 2/4/08.**
- **Consultation dated 6/5/07.**

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years
Gender: Male
Date of Injury: xx/xx/xx
Mechanism of Injury: Felt a pop in his back while pulling on an air compressor with a partner and using extra force to move the air compressor.

Diagnosis: Degenerative disc disease.

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

The claimant is a xx-year-old male with the date of injury of xx/xx/xx. The mechanism of injury was described as the claimant was pulling on an air compressor with a partner and having to use extra force to move the compressor, he felt a pop in his back. The claimant subsequently was seen and evaluated with the company doctor who performed X-rays and pain medications, muscle relaxants, and anti-inflammatories were prescribed and then the claimant was seen by a chiropractor. The claimant was seen by Dr., June 5, 2007, complaining of back and leg pain. The physical examination on that date revealed positive right straight leg raising, 1-cm atrophy of the right calf, dorsiflexor and plantar flexor weakness, right compared to left, and L5-S1 sensory decreases. The claimant was unable to toe and heel walk due to the weakness. An MRI had been performed which revealed a large L5-S1 herniated disk and an L4-L5 herniation was noted. The claimant was subsequently taken to surgery on June 20, 2007, where an L4-L5 and L5-S1 laminectomy/diskectomy was performed by Dr.. The claimant, postoperatively, did have a decrease in his pain. He was wearing a brace and was then sent to physical therapy. The claimant continued to have symptoms into the calf, with tightness and cramping and weakness. He underwent an electrodiagnostic study, on October 29, 2007, where a subacute right S1 radiculopathy was noted. At the date of that evaluation

by Dr., his physical examination noted decreased sensation lateral border of the right foot, diminished Achilles 1+/2, and range of motion was diminished with pain on extension and flexion. After his evaluation, the claimant followed with Dr., with ongoing complaints of radicular pain, right-sided calf with weakness noted. A repeat MRI of the lumbar spine was performed on January 11, 2008 that revealed a right paracentral lateral 3 to 4 mm protrusion/herniation creating compression, right side of the thecal sac and right S1 nerve root encroachment. The January 30, 2008 note by Dr. indicated some residual pain, mainly in the right calf, but not what he had before and he was able to work modified duty.

The rationale for an adverse determination of the epidural steroid injection is the claimant did not appear to have a clear-cut radiculopathy as recommended by the Official Disability Guidelines (ODG), and with the January 30, 2008 note indicating some residual pain but he was able to work, the clinical condition appears to be improving. Therefore, at this time, this reviewer does not feel the requested epidural steroid injection is supported by the medical records provided for review as being medically necessary.

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

□ ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.
Official Disability Guidelines (ODG), Treatment Index, 6th Edition (web), 2008, Low back—Epidural steroid injections (ESIs), therapeutic, Epidural steroid injections, "series of three"

- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).