

**C-IRO, Inc.**  
**An Independent Review Organization**  
7301 Ranch Rd. 620 N, Suite 155-199  
Austin, TX 78726

Notice of Independent Review Decision

**DATE OF REVIEW: MARCH 16, 2008**

**IRO CASE #:**

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

Lumbar epidural steroid injection under fluoroscopy (2 visits, 2 weeks apart); trigger point injection 4-6 (2 visits, 2 weeks apart); epidurography.

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 2/6/08, 2/27/08  
ODG Guidelines and Treatment Guidelines, Epidural Steroid Injections  
MD, 1/31/08, 1/3/08, 11/20/07, 9/20/07, 8/21/07, 6/19/07, 4/5/07, 12/5/06, 11/7/06,  
9/5/06, 8/3/06, 5/26/06  
CT Lumbar Spine, 4/20/06  
CT Thoracic Spine, 4/20/06

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured while on the job when he fell 28 feet. Most recently, he has been described as suffering from low back pain that radiates down the right leg to the ankle. Physical exam was significant for trigger point tenderness to the quadratus lumborum, gluteus maximus and gluteus medius muscles. There were no objective findings for radiculopathy. It is also noted that the patient has received trigger point injections to the quadratus lumborum, gluteus maximum and gluteus medius muscles. Per the office visit note dated 06/19/07, the patient received “greater than 30% long-term benefit.”

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

Lumbar epidural steroid injection – Per the *Official Disability Guidelines*, there must be objective findings on physical exam for radiculopathy. This is not noted in the office visit note when the epidural steroid injection was recommended. In addition, the MRI report of a small central disc protrusion at L5-S1 does not correlate with the patient’s description of symptoms. Unfortunately, these symptoms are not well described in the office visit note. Specifically, a dermatomal distribution is not described. Therefore, based on this information, the epidural steroid injection is not indicated.

Trigger point injections – Per the *Official Disability Guidelines*, trigger point injections should not be repeated unless “greater than 50% pain relief with reduced medication use is obtained for six weeks after an injection.” Per the office visit note date 06/19/07, the patient had received “greater than 30% long-term benefit” after receiving trigger point injections to the quadratus lumborum, gluteus medius and gluteus maximus muscles. Given that this does not follow the *Official Disability Guidelines*, this procedure is not indicated.

The reviewer finds that lumbar epidural steroid injection under fluoroscopy (2 visits, 2 weeks apart); trigger point injection 4-6 (2 visits, 2 weeks apart); epidurography is not 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 & 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)