



Southwestern Forensic
Associates, Inc.

DATE OF REVIEW: 11/22/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left L5/S1 epidural steroid injection.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.O., licensed physician in the State of Texas, with over twenty years in the active practice of Pain Management, fellowship trained in Pain Management, Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Medicine

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. Lumbar MRI scan dated 12/03/05
2. Medical records of Dr.
3. Lumbar MRI scan dated 08/22/07
4. Reports of previous physician advisers regarding this request

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This claimant was allegedly injured on xx/xx/xx while lifting a wooden pallet. The claimant had lumbar MRI scan on 12/03/05, which demonstrated shallow central disc protrusion and mild facet arthrosis at L4/L5 with 1.1-cm left subarticular disc protrusion impinging on the left S1 nerve root at L5/S1. The claimant subsequently underwent two lumbar epidural steroid injections with no relief as well as physical therapy and chiropractic care, similarly with no relief.

On 08/08/07 the claimant was evaluated by Dr. for complaint of primarily lumbar pain constituting 75% of her symptoms as well as pain radiating down the left leg with numbness and paresthesias constituting 25% of the claimant's symptoms. Physical examination by Dr. documented normal strength in all muscles of both lower extremities, normal sensation in all lumbar dermatomes, negative straight leg raising test bilaterally, and normal reflexes at the patella and Achilles tendons bilaterally. Dr. recommended a repeat lumbar MRI scan.

That MRI scan was performed on 08/22/07, demonstrating mild dehydration of the L3/L4 disc with a small central herniation, dehydration of the L4/L5 disc with a small central protrusion, and dehydration of the L5/S1 disc with a "tiny" central disc protrusion. No canal or foraminal stenosis was noted at any level nor any spinal cord or nerve root compromise.

Dr. continued to follow the claimant, documenting the same pain complaints and same negative physical examination through July 2008. On 08/19/08 Dr. performed a left L5/S1 transforaminal epidural steroid injection, following up with the claimant approximately two weeks later on 09/03/08, documenting "30%" relief of pain with a reduction in pain level from 7/10 to 6/10.

Dr. then submitted a request to repeat the injection, which was reviewed on 09/22/08 and found to be medically unnecessary by the physician reviewer. The reviewer noted that the claimant had "only 30% relief" and that the claimant was apparently not doing any type of home exercise.

Dr. then followed up with the claimant on 09/24/08, documenting the same normal neurologic exam and negative straight leg raising test bilaterally, submitting a reconsideration for a repeat left L5/S1 epidural steroid injection.

That reconsideration was evaluated on 10/14/08 and again found to be medically unnecessary. The reviewer noted that imaging studies revealed only "minimal pathology" with "no evidence of nerve root compression," and that there was also "no objective evidence of lumbar radiculopathy."

On 10/24/08 Dr. followed up with the claimant, documenting continued lumbar pain with left leg radicular symptoms "partly through the posterior thigh." Straight leg raising test was still negative bilaterally.

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

According to ODG Treatment Guidelines lumbar epidural steroid injections are medically reasonable and necessary when there is radicular pain consistent with a dermatomal distribution that is concordant with MRI scan findings as well as the presence of radiculopathy as evidenced by either physical examination or electrodiagnostic testing. In this case, none of those criteria is present. The MRI scan demonstrates no evidence of clinically significant findings, no evidence of disc herniation

causing either spinal cord or nerve root compression, and no evidence of focal disc herniation. The claimant's pain complaints do not follow a dermatomal distribution consistent with L5/S1 symptomatology as the symptoms radiate only to the posterior thigh, which is not consistent with either L5 or S1 dermatomal pain distribution. Finally, physical examination has repeatedly and consistently demonstrated absence of any focal neurologic findings. Physical examinations, in fact, continually and repeatedly document normal reflexes, normal sensation, normal strength, and negative straight leg raising test bilaterally. Therefore, this claimant has no physical examination evidence of radiculopathy, no MRI scan evidence of disc herniation causing neural compromise or compression and a nondermatome pain distribution inconsistent with the request for performing injection at the L5/S1 level. Finally, and perhaps just as important, this claimant has already had an identical procedure performed, which allegedly provided her with 30% pain relief, but in actuality provided much less pain relief than that since the claimant's pain level reduced from a level of 7/10 to 6/10, which is no more than a 15% reduction in pain. Such a minimal reduction in pain does not justify repeating the procedure, especially given the absence of all of the other criteria that would otherwise support doing the procedure. Therefore, the previous recommendations for nonauthorization by two separate physician advisers are upheld. The request for left L5/S1 epidural steroid injection is not medically reasonable or necessary and has no valid medical indication according to ODG Treatment Guidelines and nationally accepted standards of care.

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

(Check any of the following that were used in the course of your review.)

- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)