

**SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.**  
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Notice of Independent Review Decision

**DATE OF REVIEW:** April 16, 2009

**IRO CASE #:**

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

Lumbar caudal epidural steroid injection, CPT code 62311

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

Diplomate, American Board of Anesthesiology; Diplomate, American Academy of Pain Management

**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**

**PATIENT CLINICAL HISTORY:**

This is a male who sustained a work-related injury on xx/xx/xx involving the lumbar spine. Subsequent to the injury, the patient underwent a left hemilaminectomy at the L5-S1 level. This patient's current diagnosis is lumbar post laminectomy syndrome, lumbar spondylosis, lumbar strain, and radicular pain.

In August of 2007 due to back pain with radiation to the lower extremities, the patient underwent lumbar epidural steroid injections on at least two occasions with suboptimal relief.

Due to persistence of symptoms, a lumbar MRI was performed in November of 2007 which revealed post surgical changes, consisting of left hemilaminectomy at the L5-S1 level; diffuse disc bulge asymmetric to the left, with superimposed mild left paramedian disc herniation with slight extrusion superiorly; mild central canal stenosis and bilateral neuroforaminal narrowing at the L5-S1 level. At the L3-4 level, there is asymmetric disc bulge to the left of the midline. There is mild central canal stenosis at this level and multilevel degenerative disc disease and facet joint osteoarthritis in the lumbar spine.

In the year 2008, the patient was referred to a pain management physician, M.D., who diagnosed the patient with lumbar spondylosis and chronic low back pain.

Diagnostic lumbar medial branch nerve blocks were performed on August 26, 2008, with reportedly 60% improvement in back pain.

Subsequently, this was followed by radiofrequency ablation of the above lumbar medial branch nerves as of February 13, 2009, which provided approximately 50% pain relief.

From the last submitted progress note by Dr. dated March 10, 2009, the patient is mainly complaining of low back pain “with pain going into the right lower extremity.” The physical examination reveals tenderness in the lumbar paravertebral musculature. The range of motion decreased in flexion and extension; no lower motor focal deficits, motor strength 5/5; straight leg raising was negative; gait minimally antalgic.

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

The description of services in dispute is lumbar caudal epidural steroid injection.

After a review of the information provided, the previous non-authorization for a lumbar caudal epidural steroid injection has been upheld because: 1) Lack of available relative clinical information in support of the application (request) particularly no information regarding the presence of significant objective radiculopathy exists on the followup notes submitted. The Official Disability Guidelines clearly indicate that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In addition, the previously performed procedures have resulted in unsustained pain relief. The Guideline References used: Official Disability Guidelines, Treatment Index, 5<sup>th</sup> Edition, 2008, under lumbar epidural steroid injection.

The review outcome is upheld.

**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)**