



Notice of Independent Review Decision

**IRO REVIEWER REPORT**

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**DATE OF REVIEW:** 8/18/09

**IRO CASE #:**

**NAME:**

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

Determine the appropriateness of the previously denied request for lumbar epidural steroid injection (ESI), L3-5.

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

Texas licensed Neurosurgeon

**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.

The previously denied request for lumbar ESI, L3-5.

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- **Certification of Independence of the Reviewer Sheet dated 8/12/09.**
- **Fax Cover Sheet dated 8/10/09.**
- **Notice to , of Case Assignment Sheet dated 8/10/09.**
- **Notice to utilization Review agent of Assignment of Independent Review Organization Sheet dated 8/10/09.**
- **Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 8/10/09.**
- **Request for a Review by an Independent Review Organization Form dated 8/7/09.**
- **Notice of Utilization Review Findings Form dated 8/6/09.**
- **Copy of a Letter dated 8/6/09, 7/30/09.**
- **Notice of Utilization Review Findings Report dated 7/30/09.**
- **Appeal Information Sheet dated 7/29/09.**
- **Patient Information Sheet dated 7/28/09.**
- **History of Present Illness Report dated 7/27/09.**
- **Follow-Up Report dated 6/23/09, 5/8/09, 2/6/09, 11/4/08, 9/2/08, 3/13/08, 2/7/08, 1/31/08, 1/15/08, 1/4/08, 12/13/07, 11/30/07, 10/26/07, 9/25/07, 9/4/07, 8/23/07, 7/31/07, 7/17/07, 6/14/07, 4/17/07, 3/20/07, 2/13/07, 1/9/07, 10/24/06, 8/11/06, 6/28/06, 1/25/06, 10/11/05, 9/27/05, 7/12/05, 6/7/05, 5/31/05, 5/24/05, 3/8/05, 2/21/05, 1/28/05, 1/11/05, 11/2/04, 10/13/04, 7/14/04, 5/26/04, 4/19/04, 2/16/04, 2/3/04, 12/17/03, 11/19/03, 11/14/03, 10/17/03, 9/15/03, 8/22/03, 7/25/03, 7/22/03, 7/21/03, 6/27/03, 6/20/03, 5/30/03, 5/7/03, 4/28/03, 4/21/03, 4/8/03, 3/31/03, 3/11/03, 2/28/03, 2/21/03, 2/19/03, 1/21/03, 12/3/02, 10/7/02, 7/18/02.**
- **Radiology Report dated 6/10/09, 7/17/07, 4/17/07, 1/4/08.**
- **Lumbar Spine X-Ray Findings dated 9/27/05.**
- **MRI of Lumbar Spine with and without Contrast Report dated 2/10/05, 4/18/03.**
- **X-Ray of Pelvis Note dated 6/4/04.**
- **X-Ray of Left Hip Note dated 6/4/04.**
- **X-Ray Note of Lumbar Spine Note dated 6/4/04.**
- **Lumbar Spine Viewing Note dated 2/3/04.**
- **Patient Examination Results dated 6/9/09 thru 5/18/09.**
- **MRI of Lumbar Spine without Contrast Report dated 5/18/09, 7/8/02.**
- **Lumbar Spine X-Ray Image dated 5/18/09.**
- **SOAP Note dated 7/29/09, 4/28/09, 12/1/08, 9/26/08.**
- **Electromyograph/Nerve Conduction Study Report dated 2/26/08.**
- **Motor Nerve Conduction/Sensory Nerve Conduction Study dated 2/26/08.**
- **Further Anterior Column Stabilization Request/Letter dated 8/31/06.**

- Further Treatment Request/Letter dated 4/15/04.
- Re-Exploration Request/Letter dated 3/24/04.
- Patient Vital Signs Note dated 8/19/03.
- Computerized Tomography of Lumbar Spine without Contrast Note dated 8/1/03.
- Lateral Viewing of Lumbar Spine Note dated 6/20/03, 4/8/03, 2/19/03, 1/6/03, 1/3/03.
- History of Present Illness Report dated 3/5/07, 1/6/03, 10/18/02
- MRI of Thoracic Spine without Contrast Note dated 12/30/02.
- Computerized Tomography, Post Discography Note dated 11/18/02.
- Discharge Summary dated 1/11/03.
- Procedure Note dated 7/21/03, 6/23/03, 5/12/03, 4/7/03, 11/18/02, 9/9/02.
- Operative/Postoperative Report dated 3/5/07, 1/6/03.
- X-Ray of the Chest Note dated 3/2/07.
- X-Ray of Fluoroscopy Note dated 3/5/07.
- Intraoperative Monitoring Report dated 1/6/03.

There were no guidelines provided by the URA for this referral

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age: xx years**

**Gender: Male**

**Date of Injury: xx/xx/xx**

**Mechanism of Injury: Strained lower back cleaning up scrap on a ramp.**

**Diagnosis: Lumbar disc displacement, post laminectomy syndrome.**

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

This xx-year-old male sustained an injury on xx/xx/xx, after picking up metal. He is status post L2-L3 bilateral laminectomies and fusion (2003) and repeat fusion in 2007. He complained of increasing back and bilateral leg pain. Previous injections (ESI's) were noted to be ineffective. His last neurological examination by the provider on 07/27/2009, was essentially normal. An MRI of the lumbar spine dated 05/18/2009, showed an L5-S1 disc herniation, with bilateral neuroforaminal narrowing. There was mild spinal stenosis at L4-L5, with mild bilateral foraminal narrowing. L3-L4 was described as normal. An electromyogram/nerve conduction velocity (EMG/NCV) study on 02/26/2008, showed subacute bilateral L5 and S1 radiculopathies. The provider is recommending a lumbar epidural steroid injection from L3-L5. The epidural steroid injection from L3-L5 is not medically necessary. While the claimant had EMG evidence of radiculopathies at the L5-S1 levels and neuroimaging revealed bilateral neuroforaminal narrowing, the proposed level of injection is L3-L5. According to the most recent MRI report of 05/2009, the L3-L4 level was normal. According to the Occupational and Disability Guidelines, ESI's are

indicated when there is objective evidence of radiculopathy that is correlated with neuroimaging. In this case, any objective evidence of radiculopathy (neuroimaging and EMG findings) was not at the level of the proposed injection. Therefore, the requested ESI 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 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.
- ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES. 7<sup>th</sup> Edition, 2009, 2<sup>nd</sup> Edition, Low back; Epidural Steroid Injection.
- 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).