



Notice of Independent Review Decision

**DATE OF REVIEW:** 1/30/09

**IRO CASE #:**

**NAME:**

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

Determine the appropriateness of the previously denied request for lumbar epidural steroid injections at L4-5.

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

**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 epidural steroid injections at L4-5.

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

- Independent Review Organization Summary dated 1/27/09.
- Cover Letter dated 1/27/09.
- Fax Cover Sheet dated 1/26/09, 1/23/09
- Notice to CompPartners, INC. of Case Assignment dated 1/26/09.

- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 1/23/09.
- Request Form – For a Review by an Independent Review Organization dated 1/22/09.
- Review Determination dated 1/16/09, 1/12/09.
- Report of Medical Evaluation dated 12/29/08, 7/3/08.
- Designated Doctor Evaluation dated 12/29/08.
- Texas Workers' Compensation Work Status Report dated 12/24/08 - 7/2/08.
- Orthopedic Consultation Report dated 12/18/08.
- Notice to Attend an Examination with Physician dated 12/10/08.
- Daily Progress Note dated 11/12/08 – 8/14/08.
- Consultation Report dated 11/10/08 – 10/8/08.
- Imaging Report – Lumbar Spine dated 10/16/08.
- Initial Consultation Report dated 9/4/08.
- Work/School Release dated 9/4/08.
- SOAP Note dated 8/20/08.
- Supplemental Report of Injury dated 8/15/08, 7/3/08, 1/2/08.
- Therapy Discharge Note dated 7/3/08.
- Progress Note dated 7/3/08.
- Employers First Report of Injury or Illness dated 7/2/08.
- Physician Activity Status Report dated 7/2/08.
- Examination Report dated 7/2/08.
- Therapy Activity Status Report dated 7/2/08.
- Associate Statement – Workers Compensation (unspecified date).
- Narrative History (unspecified date).
- Referral Form (unspecified date).
- Lumbar X-Ray Results (unspecified date).
- Information - Company Request for IRO (unspecified date).

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:**

**Gender: Male**

**Date of Injury:**

**Mechanism of Injury: Moving boxes.**

**Diagnosis: L4-5 bulge and radiculitis.**

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

The claimant is a male who was injured on xx/xx/xx, when he was moving boxes and developed low back pain. The most recent diagnoses for the claimant were an L4-5 bulge and radiculitis. On 07/02/08, Dr. saw the claimant for pain in the lumbar area. On examination, he had normal reflexes, a negative straight leg raise and decreased motion. X-rays were negative. He was given Toradol and work restrictions. The claimant was also referred for therapy. The claimant did not improve and was referred to Dr. On 09/04/08, Dr. evaluated the claimant for

low back pain into the buttocks and legs. On examination, there was tenderness and decreased motion, normal reflexes and 5/5 strength. Straight leg raise was negative and he was able to toe and heel walk. The impressions were lumbar strain and radiculopathy. Medications, therapy and modified work were recommended. Drs. provided chiropractic and therapy for the claimant. On 10/08/08, Dr. reported the claimant's low back pain into buttocks and legs was getting worse. The examination remained negative for neurological changes. Recommendations remained unchanged. A 10/16/08 MRI of the lumbar spine was normal from T12 to L3-4. There was a disc bulge at L4-5, with slight narrowing of the lateral recesses bilaterally; mild hypertrophy of the ligamentum flavum was causing slight canal central stenosis. There was L5-S1 hypertrophy of the facet on the left causing mild lateral recess stenosis. The examination was the same on 10/22/08 and chiropractic treatment was ongoing. On 12/18/08, the claimant was referred to Dr. with complaints of low back pain with tingling into the feet. On examination, there was tenderness and spasm. Straight leg raise was positive bilaterally. Reflexes were normal and strength and sensation were intact. Dr. noted the MRI showed L4-5 bulging. His impression was L4-5 bulge with radiculitis and an epidural steroid injection was recommended. Based on the medical records provided for review, epidural steroid injections are not medically indicated or appropriate after the xx/xx/xx injury. This claimant was six months post injury in a chronic setting. It was clear that the subjective complaints have been that of back pain. It did radiate to his legs, but there was no clinical radiculopathy noted. There was no abnormality noted of the neurologic assessment and he had good motor, sensation and reflexes. The MRI did not demonstrate any neural compressive lesion, which may benefit from local administration of steroids to decrease swelling in that area. Based upon these records, epidural steroid injections are not indicated.

**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 Treatment in Worker's Comp 2009. Low Back-Epidural steroid injections (ESIs), Therapeutic. “Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts.”

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).