



Notice of Independent Review Decision

DATE OF REVIEW: 07/20/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Epidural Steroid Injection

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

Board Certified in Orthopedic Surgery
Fellowship in Spinal Surgery

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.

Lumbar Epidural Steroid Injection – Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MRI of Left Shoulder, M.D., 06/19/08, 01/17/09

- Initial Examination, D.O., 06/30/08
- Follow Up Examination, Dr. 07/10/08, 07/30/08, 08/19/08, 11/19/08, 12/09/08, 01/09/09, 01/29/09, 02/18/09, 03/05/09, 03/23/09, 04/28/09, 05/08/09, 05/12/09
- Review of Services, 07/18/08, 02/16/09
- Chest X-ray, M.D., 08/26/08
- MUA Operative Report, Dr. 08/28/08, 05/14/09
- Post-Operative Visit, Dr. 09/30/08, 05/15/09, 05/28/09
- Lumbar Spine X-rays, Dr. 11/19/08
- MRI of the Lumbar Spine, M.D., 12/26/08
- Initial Examination, D.O., 01/14/09
- Follow Up Examination, Dr. 04/07/09
- Hydrocodone Prescription, Dr. 05/04/09
- Denial Letter, 05/12/09, 05/21/09
- Initial Evaluation/Plan of Care, Physical Therapy, 06/08/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient injured his back and left shoulder while moving fenders off a belt. He underwent two MRI's of the left shoulder and one of the lumbar spine. He also had two surgeries performed on his left shoulder. He most recently had been treated with Hydrocodone-Acetaminophen and received an injection in his left shoulder of Decadron with Xylocaine.

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

After my evaluation of the information provided, I believe that the patient would benefit from lumbar epidural steroid injection. According to the medical documentation reviewed, the patient is suffering from low back pain and radicular leg pain consistent with an L2 neuropathy. The etiology of the radicular pain appears to be a far-lateral disc herniation at the L2-L3 region. However, the patient does suffer from diffuse low back pain and has an MRI revealing diffuse spondylotic changes. If this patient's predominant complaint is in fact, as the medical documentation suggests, an L2 radiculopathy as diagnosed by Dr. the injection of choice would be an L2 selective nerve root block, not only as a therapeutic intervention but also a diagnostic intervention to further guide the course of future treatments. The records document the patient is currently participating in physical therapy and at this point in time, the recommended injection would be a reasonable intervention.

The Official Disability Guidelines clearly state that epidural steroid injection for therapeutic purposes for the alleviation of short term radicular pain in conjunction with active rehabilitative efforts is reasonable.

**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)**