



Notice of Independent Review Decision

DATE OF REVIEW: 06/04/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left Epidural Steroid Injection via Transforaminal Approach

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

Board Certified in Physical Medicine & Rehabilitation

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- History & Physical, M.D., 11/11/08
- MRI Lumbar Spine, M.D., 12/16/08
- Progress Note, Dr. 12/23/08, 03/04/09, 04/07/09
- Procedure Note, Dr. 02/19/09
- EMG, M.D., 03/26/09

- Request for Left Epidural Steroid Injection via Transforaminal Approach, Dr. 04/13/09
- Denial Letter 04/15/09, 04/20/09, 04/30/09
- Response to Denial Letter, Dr. 04/27/09
- Reconsideration Request for Left Epidural Steroid Injection Transforaminal Approach, Dr. 04/28/09
- Response to 2nd Denial, Dr. 05/04/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient had missed a step on a ramp at work and then began having pain in her lower back, left hip and left knee. An MRI of the lumbar spine was completed; she has undergone a lumbar epidural steroid injection, and an EMG has been performed.

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

Based upon the reviewed documentation, the requested procedure of a left transforaminal epidural steroid injection is not reasonable and necessary based upon the normal MRI of 12/17/08, the poor response to epidural steroid injection of 02/19/09, and an EMG of 3/26/09, which documents simply L4 positive sharp waves, 1+. Electrodiagnostic testing uses both a subjective and objective test. If the physician who performed the test himself documented simply 1+ positive sharp waves at the L4 level, this is not diagnostic of a true radicular lesion. No needle localization techniques have been documented which truly are able to localize the needle tip to the L4 paraspinal musculature. The positive sharp wave are rated 1+ to 4+ and as such, given the absence of specific needle localization along with the entire normality of the MRI, there is no evidence in the medical record to support the use of an L4-5 transforaminal epidural steroid injection to support the treatment of this patient's pain.

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)**