



RYCO
MedReview

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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 03/30/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

One Lumbar Epidural Injection Under Fluoroscopy

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

Board Certified in 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)

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

- Initial Consultation and Evaluation, M.D., 10/14/05
- Follow up Examination, Dr., 11/22/05, 01/03/06, 02/09/06, 03/23/06, 05/18/06, 08/17/06, 09/28/09, 11/07/06, 01/30/07, 02/27/07, 03/13/07, 03/23/07, 04/10/07, 05/15/07, 06/26/07, 08/09/07, 09/18/07, 12/11/07, 05/15/08, 07/01/08, 12/23/08, 02/17/09,
- MRI Lumbar Spine w/o Contrast, Unknown Provider, 04/12/07
- Preauthorization Request, Dr., 02/18/09
- Rehabilitation Preauthorization Request, Dr., 02/18/09
- Follow up after MRI, , M.D., 02/18/09
- Denial letter, 03/05/09, 03/09/09
- Response to Request for IRO, , 03/16/09
- The ODG Guidelines were provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was working as a xxx and as she was trying to place a file on the bottom of a shelf, she moved in a twisting movement and squatted down putting the file on the shelf. She felt a sharp stabbing pain to the low back and she was unable to stand or straighten her back. As she sat down to calm her pain, she had a sharp pain to her right buttock. She had numerous visits with Dr., a pain management specialist, including a series of epidural injections with trigger point injections, an MRI of the lumbar spine and prescription medications of Norco and Lyrica.

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

Dr. citing of ODG Treatment Guideline recommendations for support of lumbar epidural steroid injection is correct in his 02/17/09 office visit note. However, it is abundantly clear that this patient has no evidence of lumbar radiculopathy by either physical examination or electrodiagnostic studies and that her complaint of pain radiating to the anterior thigh and gluteus region is not consistent with the MRI scan findings of foraminal stenosis at L5/S1. The claimant does not have a dermatomal pain distribution consistent with either the L5 or S1 nerve roots. Moreover, neither Dr. nor Dr. documents any physical examination evidence of neurologic deficit, positive straight leg raising test, or any other signs of radiculopathy. Therefore, per the ODG Treatment Guidelines, this patient clearly does not meet the criteria for lumbar epidural steroid injection. Nonspecific decreased sensation in both lower extremities is neither evidence of radiculopathy nor a valid medical indication for performing lumbar epidural steroid injections. There is no medical reason or necessity for performance of lumbar epidural steroid injections. Therefore, per ODG Treatment Guidelines, the recommendations for nonauthorization of the requested lumbar epidural steroid injection are 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)**