

SENT VIA EMAIL OR FAX ON  
Mar/30/2009

## Applied Resolutions LLC

An Independent Review Organization  
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**DATE OF REVIEW:**  
Mar/23/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Right Lumbar ESI L5/S1 #3

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

Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management  
Subspecialty Board Certified in Electrodiagnostic Medicine  
Residency Training PMR and ORTHOPAEDIC 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines  
Denial Letters 1/14/09 and 1/29/09  
Records from Clinic 8/20/08 thru 1/29/09  
MRI 8/20/08  
1/26/09  
Letter from Patient 1/23/009  
Dr 10/28/08

**PATIENT CLINICAL HISTORY SUMMARY**

This is a femake injured at work on xx/xx/xx. She had back pain with reported pain to her right buttock and intermittent pain to the left leg. She had burning feet that Dr. attributed to a polyneuropathy. The examination provided by Dr. on his initial visit (9/19/08) described a largely intact neurological examination. The MRI done on 8/20/08 described facet changes and disc bulges at several levels. There was a small herniation described at L4/5 and a possible one at L3/4. There was slight narrowing of the left neural foramin at L3/4. She was felt to have a radiculitis. She has been on Vicodin and Zanaflex. Dr., in his DD examination

on 10/28/08 described her right lower extremity pain. She wrote in her handwritten letter of appeal of her right lower extremity pain relief after the second epidural injection. Dr. also described a normal neurological examination. Her first epidural injection at L5/S1 was done on 9/30/08. She reported significant improvement of leg pain (Note the record described back and buttock pain and not lower extremity pain). A second ESI performed on 11/12/08 reportedly improved some of her symptoms. A third ESI was scheduled and not approved. Her pain and exercises were helping.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

First, there is the requirement for the documentation of a radiculopathy or radiculitis. The pain needs to follow a specific nerve root pattern. There was a mention of right lower extremity pain by the patient and by Dr., but not by Dr.. The pain description did not follow a definitive nerve root pattern. The neurological examination was twice described as normal. There was no measurable muscle atrophy. There were no electrodiagnostic studies. So, although she has pain in her back and right lower extremity, she does not appear to meet the requirements for a radiculopathy as set by the ODG.

The ODG specifies the indications for epidural injections in the lumbar spine. As noted, she did not meet the criteria for a radiculopathy. The ESIs can provide up to 3 months of relief. This appears to be along her pain relief pattern. Further those people who receive epidural injections are required to have additional therapy. There is a passing comment by Dr. that she was improving with the therapy. The ODG cites the Cochrane study of the inconclusive results of spinal injections as compared to the AAN assessment. Further, the ODG criteria allow for repeat ESIs up to 4 a year with symptom relief lasting 6-8 weeks. It strongly does not encourage more than two ESIs, and it does not support the 'series of 3" that was once done.

Therefore, although this lady had pain relief, there has not been documentation provided of a definite radiculopathy. She had two epidural injections, but there was no justification for a third in the absence of a proven radiculopathy.

ODG:

Epidural steroid injections (ESIs), therapeutic  
Epidural steroid injections, "series of three

#### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)