



Notice of Independent Review Decision

**DATE OF REVIEW:** 9/28/09

**IRO CASE #:**                      **NAME:**

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

Determine the appropriateness of the previously denied request for lumbar epidural steroid injection, times 2 with fluoroscopy.

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

Texas licensed Physical Medicine and Rehabilitation/Pain Medicine Physician.

**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 injection, times 2 with fluoroscopy.

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

- Electrodiagnostic Study Report dated 7/28/09.
- Physician Advisor Report dated 7/21/09.
- Follow-Up Note dated 8/11/09, 7/14/09.

- MR-Lumbar Spine date 7/9/09.
- Initial Office Visit dated 6/25/09.
- Adult Progress Note dated 1/9/09.
- Appeal Denial Ltr/Comp Issues dated 8/10/09.
- Appr Ltr/Comp Issues dated 7/21/09.
- Workers' Compensation Pharmacy Fee Schedule – Simple Prescription dated 3/1/07.

There were no guidelines provided by the URA for this referral.

### **PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:**

**Gender: Female**

**Date of Injury: xx/xx/xx**

**Mechanism of Injury: Motor vehicle accident**

**Diagnosis: Lumbar disc degeneration with lumbar strain.**

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

This female sustained an industrial motor vehicle accident on xx/xx/xx, which resulted in an injury to her lower back. Reportedly, she was on her way to a local grocery store to check on merchandise when she struck a parked vehicle sustaining her lower back injury. She received conservative physical therapy treatment, which was not successful. Dr. performed an initial evaluation of the claimant on June 25, 2009. The claimant demonstrated normal mental status examination and normal cranial nerve findings. No cerebellar dysfunction was noted. Left anterior thigh pinprick sensation was impaired. Deep tendon reflexes were 2+ at the knees and ankles. The plantar response was flexor. Lower extremity manual muscle testing was 5/5-normal. After the initial physical medicine evaluation by Dr., dated June 25, 2009, the claimant underwent a lumbar MRI scan on July 9, 2009, which demonstrated disk bulging at L3-L4 and L5-S1 levels with degenerative changes. The claimant returned for a subsequent follow-up visit with Dr. on July 14, 2009, and subsequently for lower extremity electrodiagnostic study dated July 28, 2009, which was an EMG needle examination demonstrating medial and lateral gastrocnemius slightly increased degree of polyphasic of the right medial and lateral gastrocnemius muscles which Dr. interpreted as a left S1 nerve root irritation, however, there was no evidence of any spontaneous activity-abnormal positive sharp waves or fibrillations to support evidence of ongoing denervation. The claimant returned to Dr. for continuing physical medicine follow-up care on August 11, 2009. He recommended that the claimant begin physical therapy treatment as the requested lumbar epidural steroid injection was not approved.

Dr. reviewed the lumbosacral spine diagnostic X-rays of flexion/extension views, demonstrating L5 sacralization. The results of L4-L5 and L5-S1 disk space narrowing. T12 anterior vertebral body wedging was noted to a minimal degree. Thoracic spine diagnostic X-rays demonstrated no evidence of scoliosis, fracture, or subluxation.

Dr. diagnosed diskogenic low back pain, rule out lumbosacral radiculopathy. He recommended a lumbosacral spine MRI scan, electromyogram/nerve conduction velocity (EMG/NCV) studies, and he recommended a trial of lumbar epidural steroid injections. He prescribed Voltaren gel to apply to the lower back and Amrix 15 mg capsules for muscle spasm. A subsequent July 9, 2009, lumbar MRI scan demonstrated mild disk bulging and disk degeneration of L3-L4, without disk herniation or central/peripheral stenosis. The L5-S1 level also demonstrated mild disk bulging with facet arthrosis.

The requested lumbar epidural steroid injection was not certified, however, the lower extremity EMG/NCV study was certified at an appeal level.

In summary, the requested lumbar epidural steroid injection is non-authorized because this request does not satisfy ODG criteria for lumbar epidural steroid injections, which includes:

1. Radiculopathy must be documented objective findings on examination need to be present for unequivocal evidence of radiculopathy, see AMA Guide, 5th Edition, Pages 382-383.
2. The claimant must demonstrate unresponsiveness to conservative treatment including physical therapy, nonsteroidal anti-inflammatory medication, and muscle relaxant medication.

In addition, ODG also states, "Use for chronic pain: Chronic duration of symptoms (> 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months." Therefore, by these guidelines, there is no medical indication for an ESI.

**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.
- ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.  
7<sup>th</sup> Edition, (web), 2009. Low back – Epidural steroid injections – All.
- 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).