

SENT VIA EMAIL OR FAX ON  
Sep/21/2009

## True Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**  
Sep/16/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Lumbar Epidural Steroid Injection

**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

**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 7/14/09 and 8/7/09  
Dr. 6/30/09 and 7/30/09  
MRI 12/7/07  
Dr. 8/4/09

**PATIENT CLINICAL HISTORY SUMMARY**

This lady was injured on xx/xx/xx. She reportedly had 3 ESIs, the last being in 5/05. She had reportedly complete relief of her pain and she returned to work. She relapsed in 6/30/09 with back pain and bilateral leg pain reportedly in the L5/S1 distribution. Her MRI in 2007 reportedly showed L5/S1 disc protrusion and an L4/5 bulge.

Dr. examination of 6/30/09 showed local tenderness and the lady complained of pain. He wanted to perform an ESI. The Reviewer did not include neurological examination. Dr. saw her on 8/4/09. He commented upon abnormal EMGs that showed bilateral L5/S1 radiculopathy, but the actual report was not provided. He also described an MRI done on 7/11/09 that showed narrowing at L5/S1 and the disc protrusion. His examination showed local tenderness. There was no obvious motor weakness with the heel and toe walking. He found no spasms. He described reduced left lateral foot sensation, reduced lumbar motion and a reduced left ankle jerk.

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

This lady had relief of her radiculopathy for xxxx after the prior ESI. The presence of the radiculopathy was documented by the motor and sensory complaints and findings by Dr. I did not have the current MRI or EMG, but presumably these documented the abnormalities Dr. reported. She met the criteria described for the therapeutic injections. The frequency now is more than a year since the last injection. She had significant benefit. The single repeat ESI is justified.

Epidural steroid injections (ESIs), therapeutic

**(1) Radiculopathy must be documented. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. ([Andersson, 2000](#))**

**(7) *Therapeutic phase:* If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be required. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. ([CMS, 2004](#)) ([Boswell, 2007](#))**

**(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.**

**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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**