

SENT VIA EMAIL OR FAX ON  
Aug/10/2010

## IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/10/2010

**IRO CASE #:**

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

Lumbar ESI #1

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

Board Certified Orthopedic Surgeon

**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

Peer Review 07/08/10, 07/16/10

Dr. OV 06/09/10

Dr. / letter of appeal 07/12/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a female claimant who sustained injuries on xx/xx/xx when she fell approximately eight feet off scaffolding. A physician record dated 06/09/10 noted the claimant followed for neck, thoracic and back pain along with headaches. The claimant was noted to have known facet lumbar syndrome with facet arthrosis. Back pain, radiating pain right leg to foot and numbness and tingling in both hands and arms was reported. Review of a lumbar MRI performed on 02/09/10 showed marked L5- S1 disc space narrowing with reactive endplate changes and bilateral L5- S1 foraminal stenosis. On examination, the claimant was found to have extensor hallucis longus weakness on the right. Conservative care had included medications and physical therapy. The impression was post concussion headaches, neck pain, disc bulge C5-6, lower back pain, lumbar degenerative disc disease L5- S1 with bilateral foraminal stenosis. Treatment options were discussed. Lumbar epidural steroid injection was recommended along with an EMG/ NCS of the upper extremities.

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

This claimant has MRI findings of marked disc space narrowing and bilateral L5-S1 foraminal stenosis, there is not a positive straight leg raise test, intact sensation to the bilateral lower extremities, and there is some extensor hallucis longus weakness on the right at 5 minus out of 5. Subjective complaints are of low back pain, tinnitus, headaches, neck pain, and

complaints of pain radiating down the lateral aspect of the right leg to the foot. Documented conservative care has included physical therapy and medications; the extent and duration of physical therapy is not documented, and the medications listed include hydrocodone and cyclobenzaprine. Evidence based ODG guidelines indicate that epidural steroid injections are appropriate in cases in which there is documentation of radiculopathy and a failed response to conservative treatment such as exercise, NSAIDS, and muscle relaxants. In this case there is not documentation of nerve root compression and while the claimant complains of pain radiating down the right leg to the foot the examination documents a negative straight leg raise test and intact sensation. Based on these findings, the criteria for proceeding with an epidural steroid injection is not met as there is not clear evidence of a radiculopathy and therefore the request for a lumbar epidural steroid injection is not recommended as medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Low Back:

**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)