

SENT VIA EMAIL OR FAX ON  
Nov/11/2010

## Applied Resolutions LLC

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

**DATE OF REVIEW:**

Nov/11/2010

**IRO CASE #:**

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

Extension-Bilateral L4 Transforaminal Epidural Steroid Injection with Epidurogram

**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 9/30/10 and 10/19/10  
Dr. 4/14/10-9/13/10  
Lumbar Spine 2/25/10  
CT Myelogram 3/30/10  
MRI 4/28/10  
Dr. 7/24/10  
11/4/10  
9/8/10  
Peer Review 7/26/10

## **PATIENT CLINICAL HISTORY SUMMARY**

This is a who developed back pain with lifting patients. The official date of injury is xx/xx/xx, although Dr. gave it a description of a cumulative problem. She had CT myelograms cited by Dr. and Dr. that reported minimal disc bulges at L3/4 and L4/5. They cited several physical examinations in their record reviews that showed positive SLR, but no neurological loss on motor or sensory examination. Dr. examination showed no neurological loss. An MRI showed disc degeneration and facet hypertrophy, but no disc herniation.

Dr. examination of 4/14/10 shoed bilateral absent knee and ankle reflexes, There was normal strength and a normal sensory exam. He found a positive right SLR. The examination of 4/26/10 described the positive SLR, but no neurological findings. There was a bilateral L4 ESI performed on 8/25/10. The 9/13 note described 50% improvement, 19 days post injection. The examination that date did not include any beyond the cranial nerves. Dr. wanted therapy and a repeat ESI.

There is a 7/24/10 note by Dr. stating she had a right L5 right radiculopathy with denervation findings in the right vastus lateralis, tibialis anterior and extensor brevis.

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

The ODG approves the use of ESIs in the treatment of radiculopathy, but this requires the documentation per the ODG and AMA criteria. This includes sensory complaints in a dermatomal distribution. This may be implied but not actually documented. Second, there must be documented physical findings of a radiculopathy. SLR is not one accepted in the AMA criteria. Dr. and Dr. did not describe any evidence of a radiculopathy. The absent reflexes described by Dr. were symmetrical and therefore did not meet the AMA criteria. The argument presented by Dr. was that the EMG performed by Dr. showed a chronic right L5 radiculopathy. The waveforms of the right tibialis anterior, medial gastrocnemius and vastus lateralis were presented with the report. The vastus is innervated by the femoral nerve and not L5 of the sciatic nerve. The EDB studies were not provided. Often, these can be abnormal in otherwise normal individuals. The studies presented of the 3 muscles did not show, in the IRO reviewer's assessment, any fibrillations or positive waves. Therefore the electrodiagnostic criteria for a radiculopathy was not met. And therefore, the diagnosis of a radiculopathy has not been established to justify the medical necessity of the repeat ESI.

On another point of argument, the ODG requires that there be at least 50% or more relief for at least 6-8 weeks before a second ESI. Even if we used the pain relief as an argument for a variance to the ODG criteria, she had 50% relief reported for 19 days post procedure.

Therefore, there are both arguments against the justification for a repeat lumbar ESI.

## **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)