

US Decisions Inc.

An Independent Review Organization
2629 Goldfinch Dr
Cedar Park, TX 78613-5114
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Epidural Steroid Injection L5-S1

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

M.D., 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

ODG Low Back Chapter

Direct, 09/09/10, 09/20/10

Dr. 09/09/02, 03/13/02, 04/10/02, 11/13/02, 06/15/03, 07/09/03, 02/04/09, 05/26/09, 06/16/09, 07/20/09, 09/28/09, 10/05/09, 11/19/09, 01/26/10, 03/30/10, 05/25/10, 06/29/10, 08/27/10

Hardware Block 07/15/09

EMG/NCS 03/13/09

X-ray 02/04/09, 09/28/09, 10/05/09, 01/26/10, 05/25/10

Myelogram 03/03/09

Operative Report 08/14/00, 08/26/00, 05/06/02, 09/23/09

Surgery Reservation

Articles

Computerized Muscle Strength Testing 2009, 2010

Conformation of Appointment 02/24/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female injured on xx/xx/xx when she was and injured her low back. The claimant had a 08/14/00 L5-S1 interbody and posterolateral fusion and on 08/26/00 a wound debridement for infection.

On 09/09/02, Dr. noted that she had back pain after surgery. A CT showed possible pseudoarthrosis and possible pain from L4-5. Reflexes and sensation were intact. Motor

was normal. Straight leg raise and femoral stretch were negative. There was tenderness at S1 and L5-S1. A discogram had been concordant for pain at L4-5 and L5-S1. Surgery was recommended On 05/06/02, Dr. carried out a laminectomy at L4-5 and a revision fusion at L5-S1 for pseudoarthrosis.

Following surgery, the claimant had persistent pain of the sacroiliac joint that was treated with therapy and medication. Her neurological status was intact. She treated into 2003.

The claimant returned to see Dr. on 02/04/09 with mild symptoms and pain in the right leg with foot numbness. There was tenderness over the screw heads, decreased sensation in right S1 and good strength. There was a mildly positive straight leg raise. X-rays showed the previous fusion. A CT myelogram and EMG were the recommendations.

A 03/03/09 CT/Myelogram showed bilateral recess narrowing at L4-5. There was mild encroachment of the foramina from L2-3 through L5-S1. No loosening of hardware or arachnoiditis was seen. The L5-S1 fusion was solid. On 03/13/09, EMG/NCS showed no lumbar radiculopathy. Dr. performed a hardware block with one-day relief. Surgery was discussed.

On 09/23/09, the claimant had removal of hardware at L5-S1, exploration of the fusion and a laminectomy with repair of a leak for headache after the hardware block.

The back pain persisted after surgery but the neurological status was intact. She was treated with therapy and medication.

On 01/26/10, Dr. reported the claimant had low back and an onset of right side numbness and tingling in the thigh. There was tenderness at the incision. There was good motion with normal strength, sensation and reflexes. X-rays showed the solid fusion. Therapy and medications were recommended.

By 06/29/10, Dr. noted ongoing back and right leg pain. A request for an EMG had been denied. The examination documented tenderness of the lumbar spine with decreased motion. Straight leg raise caused back pain. Dr. reported there was right motor weakness. The impression was claudication symptoms. He requested a CT myelogram that was not apparently done. On the 08/27/10 visit, Dr. noted the claimant had right leg worse than left, as well as back pain. The examination revealed tenderness and spasm, decreased motion and paresthesia in right L5. Dr. recommended epidural steroid injection for back and leg pain.

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

The evidence based ODG Guidelines recommend epidural steroid injection to reduce pain and inflammation as a result of neural compression. In general, radiculopathy should be documented on examination and corroborated by imaging studies and/or EMG's. Conservative care should have failed.

The claimant has had a series of surgeries on her lumbar spine. They included a lumbar fusion, subsequent re-fusion, and subsequent hardware removal with exploration of fusion. Reportedly she continues to suffer from back and leg pain. There are no recent imaging studies available. The most recent myelogram was more than a year and a half ago and describes some mild neural foraminal stenosis at the level of the previous fusion. Of note, EMG's done at the same time revealed no evidence of radiculopathy. Of note, although recommendations are for epidural steroid injection at the L5 level the patient's subjective numbness is more in the anterior thigh which would not fit that distribution.

In light of the fact that there is no distinct neural compression, no objective findings of radiculopathy, and subjective complaints of pain that would not necessarily fit the nerve root

distribution of the area being injected, the request for Lumbar Epidural Steroid Injection L5-S1 is not medically necessary in this particular setting.

Official Disability Guidelines 2010. 15th Edition, Pain-Epidural Steroid Injection

Criteria for the use of Epidural steroid injections

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit

- 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing
- 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)
- 3) Injections should be performed using fluoroscopy (live x-ray) for guidance.

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)