

# US Decisions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW: April 4, 2011**

**IRO CASE #:**

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

**Lumbar Epidural Steroid Injection using fluoroscopy and epidurography**

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

**MD, Board Certified Anesthesiologist**

**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**

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. MRI of the lumbar spine dated 08/18/10 revealed mild circumferential disc bulge at L3-4 which mildly indents the thecal sac; mild to moderate circumferential disc bulge at L4-5 mildly impressing on the thecal sac, bilateral facet arthrosis and mild bilateral neural foraminal narrowing is seen. There is mild facet arthrosis at L5-S1. EMG/NCV dated 11/01/10 revealed evidence of bilateral L4 chronic lumbar radiculopathy.

Designated doctor evaluation dated 11/04/10 indicates that on the date of injury the patient was injured when. The patient injured his right knee, neck and mid to low back. The patient underwent right knee meniscectomy on 08/23/10. The patient has a history significant for left knee surgeries in 1998, 1999, 2004 and 2006; right knee surgeries in 1990 and 2010. The patient was determined to have reached MMI as of 11/04/10 with 0% whole person impairment. DDE states diagnoses are cervical strain/sprain superimposed on chronic conditions; lumbar sprain/strain superimposed on chronic conditions; right medial meniscus

tear status post partial meniscectomy; and right shoulder strain/sprain.

Orthopedic consult dated 02/08/11 indicates that the patient complains of low back pain that radiates to the right lower extremity with numbness and tingling present. On physical examination of the lumbar spine there is severe tenderness in his mid to lower lumbar region. Deep tendon reflexes are diminished in his patellae bilaterally and 1+ in the Achilles bilaterally. He has decreased range of motion in all directions with pain. He has positive straight leg raise on the right, negative on the left. Motor strength is weakened in the entire right lower extremity as compared to the left. He has paresthesias along the lateral aspects of both lower extremities. The patient was recommended to undergo cervical and lumbar epidural steroid injections.

Initial request for lumbar epidural steroid injection using fluoroscopy and epidurography was non-certified on 03/07/11 noting that there is no evidence of radiculopathy on physical examination by designated doctor on 11/04/10. The patient has a longstanding history of neck and back pain prior to the injury on xx/xx/xx, and there are no notes in the records suggesting that MRI of the cervical and lumbar spine in 2007 are not significantly different than the one done after 07/06/10. The denial was upheld on appeal dated 03/14/11 noting that radiculopathy has not been documented by physical examination, and the Official Disability Guidelines would not support cervical and lumbar epidural steroid injection on the same date, which is what has been planned for this claimant.

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

The patient underwent designated doctor evaluation on 11/04/10. There was no evidence of lumbar radiculopathy on physical examination on this date, and the patient was determined to have reached maximum medical improvement with 0% whole person impairment. EMG/NCV dated 11/01/10 revealed evidence of bilateral L4 chronic lumbar radiculopathy. Orthopedic consult dated 02/08/11 indicates that the patient complains of low back pain that radiates to the right lower extremity with numbness and tingling present. On physical examination of the lumbar spine there is severe tenderness in his mid to lower lumbar region. Deep tendon reflexes are diminished in his patellae bilaterally and 1+ in the Achilles bilaterally. He has decreased range of motion in all directions with pain. He has positive straight leg raise on the right, negative on the left. Motor strength is weakened in the entire right lower extremity as compared to the left. He has paresthesias along the lateral aspects of both lower extremities.

However, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review to establish that the patient has been unresponsive to conservative treatment. The Official Disability Guidelines criteria require that the patient has been unresponsive to conservative treatment including NSAIDs, physical therapy, exercises and muscle relaxants. This data has not been provided. In addition, the guidelines do not permit cervical and epidural injections being performed on the same day. The reviewer finds that there is not medical necessity at this time for Lumbar Epidural Steroid Injection using fluoroscopy and epidurography.

**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)**