



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
Phone: 214 732 9359 | Fax: 972 980 7836

## Notice of Independent Review Decision

**DATE OF REVIEW: 8/07/2011**

**IRO CASE #:**

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

RIGHT LUMBAR EPIDURAL STEROID INJECTION L5-S1  
WITHOUT GADOLONIUM. 62311, 77003, 72275, 62264

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

**D.O. Board Certified in Anesthesiology and 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)



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### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	7/18/2011
Workers' Comp Services Utilization Review Determinations	5/27/2011-7/14/2011
Orthopedics Clinical Notes Via certified Mail (300 pages) Dr. Procedure Order Orthopedic Reports PubMed- Article on Epidural Steroid Injection Article on Nerve Root Blocks	Received 7/21/2011 5/27/2011 3/08/2010-7/05/2011
Evaluation Center Report of Medical Evaluation	2/09/2010
Pain and Injury Clinic Initial Exam/ Preauthorization Request	6/05/2009
MRI Radiology Report	7/28/2009
Hospital Operative Report	9/22/2010

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

Mr. is a male who sustained an injury on xx/xx/xx secondary to MVA. The patient sustained injury to the left shoulder, neck and back. Neck symptoms have resolved since the injury. For the left shoulder, the patient underwent a surgical procedure followed by physical therapy and is reporting improvement in range of motion and pain symptoms. The patient continues to complain of back pain with associated leg pain. He does have a history of back pain and history of back surgery x 2 (1982) (1985). Lumbar MRI 07/28/2009 showed postlaminectomy defect on the left side at L5-S1. There was evidence of disc bulging but no evidence of nerve root entrapment, no evidence of any significant postsurgical scar tissue, no report of neuroforaminal narrowing and no report of any significant spinal canal stenosis. The injured worker continues to complain of low back pain radiating down his right leg with occasional numbness and tingling. On exam there is severe pain in the low back with decreased ROM, muscle spasms,



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positive right leg raise test on the right, absence of patellar reflex, weak Achilles reflex, slow gait, and paresthesia in the left L5 distribution. The request is for right lumbar ESI.

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

ODG guidelines for Epidural Steroid Injections (ESIs) require findings of radiculopathy supported by objective MRI or EMG findings and do not recommend ESIs beyond 24 months.

After reviewing all information submitted, the proposed treatment: right lumbar ESI does not meet the medical necessity guidelines. Patient has a history of post laminectomy syndrome, had ESIS facet injections previously without any reported relief. Lumbar MRI showed no evidence of nerve root entrapment, no neuroforaminal narrowing, and no report of any significant spinal canal stenosis. Since there is no recent MRI, and no EMG results to support findings of entrapment or radiculopathy, the physical exam results are objective findings with little diagnostic support. Also, since the injury was about two years ago, the ODG reports little success with ESIS for injuries older than 24 months.

**REFERENCES: ODG GUIDELINES LOW BACK CHAPTER**

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN 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