**SENT VIA EMAIL OR FAX ON**
**Aug/22/2011**


# True Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**
Aug/22/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
Bilateral L4/5 Transforaminal ESI with IV sedation

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

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ X ] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**
OD Guidelines
1. Cover sheet and working documents
2. Work comp profile
3. MRI lumbar spine without contrast dated 12/21/04
4. Office visit notes dated 01/10/05-05/18/11
5. CT lumbar spine with contrast dated 12/12/05
6. XR SP Myelogram lumbosacral spine dated 12/12/05
7. X-ray lumbar spine 1 view dated 01/10/06
8. MRI lumbar spine with and without contrast dated 06/08/06
9. Electrodiagnostic study dated 03/28/07
10. Operative report dated 07/11/07
11. MRI lumbar spine with and without contrast dated 05/10/11
12. Utilization review notice of determination for request bilateral L4-5 transforaminal ESI with IV sedation dated 05/26/11
13. Treatment referral form
14. Utilization review notice of determination for appeal request bilateral L4-5

transforaminal ESI with IV sedation dated 06/28/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was lifting a crank shaft and injured his low back. Treatment to date is noted to include chiropractic care, medication management, laminectomy/discectomy at L4-5 and L5-S1 on 02/04/05, physical therapy, L4-5 discectomy in January 2006. Note dated 07/24/06 indicates that the patient underwent selective nerve root block without much relief. Electrodiagnostic evaluation dated 03/28/07 revealed electrodiagnostic evidence of a chronic and inactive right L5 radiculopathy of moderate severity. The patient underwent dorsal column stimulator placement in July 2007l; however, the patient's pain increased and all leads were extracted. Visit note dated 04/08/11 indicates that the patient continues to complain of low back pain with a burning sensation in both legs and feet. MRI of the lumbar spine dated 05/10/11 revealed status postsurgical changes at L4-5 and L5-S1; enhancing granulation tissue within the anterior aspect of spinal canal at L4-5 and L5-S1; mild-moderate bilateral neural foraminal narrowing at L5-S1 unchanged from prior exam, and slight retrolisthesis of L4 on L5.

Initial request for epidural steroid injection was non-certified on 05/26/11 noting there is no physical examination documented. There is no evidence of recurrent disc herniation on MRI. There is no objective documentation of L4-5 radiculopathy. It does not appear that conservative treatment including PT has been optimized in the recent past. The denial was upheld on appeal on 06/28/11 noting recent objective findings did not validate the presence of radiculopathy. MRI of the lumbar spine did not reveal nerve root impingement. There is no objective documentation of exhaustion of recommended conservative therapies.

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

Based on the clinical information provided, the request for bilateral L4-5 transforaminal epidural steroid injection with IV sedation is not recommended as medically necessary, and the two previous denials are upheld. There is no current, detailed physical examination submitted for review to establish the presence of active lumbar radiculopathy, and the submitted lumbar MRI does not support the diagnosis. There is no indication that the patient has undergone any recent conservative treatment including physical therapy. Given the current clinical data, the requested epidural steroid injection is not indicated as medically necessary.

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

**[ X ] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**[ X ] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**