

**Wren Systems**  
**An Independent Review Organization**  
**3112 Windsor Road #A Suite 376**  
**Austin, TX 78703**  
**Phone: (512) 553-0533**  
**Fax: (207) 470-1064**  
**Email: manager@wrensystems.com**

**NOTICE OF INDEPENDENT REVIEW DECISION**

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

**IRO CASE #:**

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

Interlaminar Epidural Steroid Injection at L3-4

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

MD, 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Official Disability Guidelines, Criteria for the use of Epidural steroid injections

MRI lumbar spine without contrast dated 04/12/11

Progress notes dated 04/26/11-06/06/11

Radiology report PA, flexion / extension, lateral of lumbar spine dated 06/06/11

Utilization review determination interlaminar epidural steroid injections L3-4 dated 06/24/11

Utilization review determination appeal interlaminar epidural steroid injections L3-4 dated 07/18/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was lifting heavy wood and injured his back. MRI of the lumbar spine dated 04/12/11 revealed 7 mm soft tissue density along the ventral epidural space extending from the L2-3 level caudally to the inferior endplate of L3. These findings are noted to be most consistent with disc protrusion/extrusion with other differential considerations. There is a 2 mm disc bulge at L5-S1 without spinal canal stenosis. Note dated 06/06/11 states that the patient complains of low back pain with numbness and tingling in the legs. The patient has undergone a course of physical therapy. On physical examination deep tendon reflexes are 2+ in the bilateral upper and lower extremities. He has normal sensation throughout. He walks with a normal ambulation. Lumbar range of motion is mildly decreased. He is able to heel and toe walk without significant difficulty. Straight leg raising is negative. Strength is normal in the lower extremities. The provider's request for epidural steroid injection was non-certified on 06/24/11. The reviewer wrote that the imaging studies do not corroborate the radiculopathy at level of the intended injection. The first denial was upheld on 07/18/11. The reviewer wrote that there is no documentation of pain, numbness and/or paresthesias in a dermatomal distribution. There is no documentation of an imaging study documenting correlating concordant nerve root pathology. There is no documentation of associated clinical findings such as relevant reflexes, muscle weakness/atrophy, and/or loss of sensation in the corresponding dermatome.

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

The ODG criteria for the use of ESI has not been satisfied. This patient's physical examination fails to establish the presence of active lumbar radiculopathy, and the submitted lumbar MRI does not support the diagnosis. The patient's physical examination notes 2+ deep tendon reflexes, intact sensation, normal strength and negative straight leg raising. Given the lack of documented radiculopathy, the reviewer finds that the requested Interlaminar Epidural Steroid Injection at L3-4 is not medically necessary.

**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)