



---

Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax:  
877-738-4395

## Notice of Independent Review Decision

### IRO REVIEWER REPORT – WC (Non-Network)

---

**DATE OF REVIEW:** 02/22/11

**IRO CASE #:**

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

L4-L5 and L5-S1 epidural steroid injections (ESIs)

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

Board Certified in Orthopedic Surgery

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

L4-L5 and L5-S1 epidural steroid injections (ESIs) - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

An evaluation dated 08/27/10  
An MRI of the lumbar spine dated 09/30/10  
An MRI of the cervical spine dated 10/01/10  
An emergency room evaluation with an unknown provider (signature was illegible) dated 11/17/10  
Evaluations dated 12/17/10, 01/27/11,  
A doctor's order dated 01/06/11  
A letter of non-certification, according to the Official Disability Guidelines (ODG), dated 01/11/11  
A letter of non-certification, according to the ODG, dated 01/31/11  
A letter of non-certification, according to the ODG, dated 02/02/11  
Undated medical criteria forms  
The ODG Guidelines were not provided by the carrier or the URA

### **PATIENT CLINICAL HISTORY**

On 08/27/10, Dr. prescribed Hydrocodone, Mobic, and Skelaxin and recommended x-rays of the cervical and lumbosacral spines and physical therapy. An MRI of the lumbar spine on 09/30/10 showed disc bulges at L1-L2, L3-L4, L4-L5, and L5-S1 with possible extrinsic compression of the nerve root sleeves at L3-L4, L4-L5, and L5-S1. An MRI of the cervical spine on 10/01/10 showed paracentral extradural defects at C2-C3 and C5-C6 and spondylosis at C3-C4. On 11/17/10, the patient went to the emergency room, was diagnosed with acute low back pain with sciatica and was given Vicodin. On 12/17/10, recommended cervical and lumbar epidural steroid injections (ESIs) with post injection therapy. On 01/11/11, Dr. wrote a letter of non-certification for the ESIs. On 01/31/11, Dr. wrote a letter of non-certification for a C5-C6 ESI. On 02/02/11, Dr. also wrote a letter of denial for the ESIs.

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

The patient's MRI obtained on 09/30/10 demonstrated small disc bulges at multiple levels. There is no impingement of the exiting nerve root sleeves at L4-L5 and minimal extrinsic depression on the left side at L5-S1. The patient's initial symptoms have all been right sided, then changing to bilateral leg symptoms. There have been no objective signs or symptoms of radiculopathy based on the documentation. The Official Disability Guidelines (ODG) does require objective evidence of both nerve root compression, as well as objective physical findings to justify performing ESIs. Therefore, the patient does not meet the minimal requirements of the ODG to perform lumbar ESIs. Therefore, the requested L4-L5 and L5-S1 ESIs are neither reasonable nor necessary and the previous adverse determinations should be upheld.

### **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 AND KNOWLEDGE BASE
- 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)

AMA Guides To The Evaluation of Permanent Impairment, Definition of Radiculopathy