

MEDR



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Notice of Independent Review Decision

DATE OF REVIEW: 12/24/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an epidural steroid injection with fluoroscopy at L4/5 on the right.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of an epidural steroid injection with fluoroscopy at L4/5 on the right.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

According to available medical records, the injured employee injured his back when he slipped on ice on xx/xx/xx. At the time of the injury, he heard and felt a popping sensation in the lumbar area and he developed low back pain with associated hip and

leg pain, especially on the right side. He had a past history of a 360° fusion at the L5-S1 level in 1989. He had done well postoperatively until the time of his reported injury on xx/xx/xx. The injured employee had extensive treatment for his back pain including chiropractic treatment, physical therapy, and multiple medications.

On May 13, 2010, the injured employee was evaluated by M.D. at the. Dr. documented paralumbar muscle tightness, tenderness at both sciatic outlets, trace deep tendon reflexes at the knees and absent deep tendon reflexes at the ankles, no sensory deficits, and straight leg raising positive at 45° to 60°. There was no comment regarding strength or atrophy. Dr. opinion was that the injured employee had developed chronic mechanical low back disorder with diskopathies and probable radiculopathies.

On June 2, 2010, epidural steroid injections were performed at the L3-4 level by M.D. Dr. saw the injured employee in follow-up on July 6, 2010. At that time, it was noted that there was no improvement following the injection. Dr. detailed note indicated that there was tenderness over the lumbar spine, no evidence of muscle spasm, limited back extension to 10°, but full range of motion of the back in other planes, normal strength, intact sensation, normal knee and ankle reflexes, and a negative straight leg raise.

On July 22, 2010, Dr. reported that the injured employee was no better and had not gotten relief from his lumbar epidural steroid injections. He recommended myelography and CT scanning.

On August 17, 2010, a myelogram and CT scan were performed. These showed central defects at L2-3, L3-4, and L4-5 but no evidence of tight stenosis, no evidence of definite nerve root compression, and no evidence of definite extruded disk. Dr. noted the above findings when he re-evaluated the injured employee on October 17, 2010. He did note that the injured employee was continuing to complain of bilateral hip and leg pain, mainly on the right side. Dr. recommended a right L4-5 epidural steroid injection and stated that the injured employee might be a candidate for a trial of a spinal cord stimulator. He stated that no direct spinal surgery was recommended at that time.

Requests for lumbar epidural steroid injections at the L4-5 level on the right were made. There were two adverse determinations for that request.

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

The injured employee injured his back when he slipped on ice on xx/xx/xx. He had a history of prior lumbar fusion at the L5-S1 level in 1989 with good surgical results. Following his xx/xx injury, he developed chronic low back pain with associated pain in the hips and legs, greater on the right side than the left. He was extensively evaluated and treated, according to records, with physical therapy, chiropractic treatment, medications, and an epidural steroid injection at the L3-4 level.

When he was last evaluated by Dr. on October 17, 2010, Dr. recommended epidural steroid injection at the L4-5 level on the right. No rationale for this request is in the medical record. The injured employee had had a lumbar epidural steroid injection at the L3-4 level with no improvement in symptoms. Myelogram and CT scan of the lumbar spine did show evidence of mild narrowing of the disk space at L4-5 with a broad-based disk bulge and mild encroachment on the anterior aspect of the dural sac and neural foramen, but there was no definite evidence of nerve root compression or extruded disk. Nowhere in the record is there an adequate description of radiculopathy. There is no evidence of reflex changes, dermatomal sensory loss or paresthesias, muscle weakness or atrophy, or electrodiagnostic changes which would suggest radiculopathy.

The ODG Guidelines clearly state that a radiculopathy must be documented by objective findings before lumbar epidural steroid injections are used and this medical record does not indicate the presence of radiculopathy. Therefore, ODG Guideline requirements for the prospective medical necessity of an epidural steroid injection with fluoroscopy at L4-5 on the right are not met. It should be noted that the prior epidural injection was at the L3-4 level, not the L4-5 level; therefore this requested injection would not be considered a repeat of his prior injection.

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 (PROVIDE A DESCRIPTION)**