

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 3, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Bilateral Lumbar transforaminal epidural steroid injection @ L4-5 (64483, 64493)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.4	64483		Prosp	1			4.26.09	E2564106	Upheld
724.4	64493		Prosp	1			4.26.09	E2564106	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient being treated is a gentleman with complaints of low back pain. An x-ray of the lumbar spine was performed following the work injury. Impression was unremarkable lumbar spine. Lumbar spine MRI was requested for correlation. His right knee and patella showed no acute osseous abnormality.

MRI of the lumbar spine was completed on 12/29/2009 at, P.A. It revealed L3-L4 mild diffuse disc bulge, superimposed bulb base right foraminal lateral protrusion at L4-L5 there is a disc bulge with superimposed central bulb base protrusion with mild effacement of ventral epidural fat abutting the ventral thecal sac. There is mild foraminal narrowing bilaterally. At L5-S1 there is mild bilateral facet arthropathy. Mild tropisms facet is seen at L5-S1. This was read by Dr. D.O.

EMG was performed and nerve conduction studies of the lower extremities on 02/03/2010 by Dr. There is moderate left L5 lumbar radiculitis and possible S1 component. There is evidence of both peripheral myotomal muscles, particularly L5 musculature on the left and the L4-L5 perispinal musculature on the left. Also noted was an increased insertional activity with positive sharp raise as demonstrated on the right L5 perispinal muscle sample. It was discussed with the patient about performing a left L4-L5 and possibly L5-S1 transforaminal epidural steroid injection. Subsequent to that, a left L4-L5 ESI was carried out by Dr. on 03/26/2010. On 04/07/2010 he returned for a follow-up visit and reported about an 80% overall improvement. On the left foot numbness and paresthesias had improved. He felt a residual pain radiating down the left lower extremity.

A second injection was performed on 04/16/2010 for a left L4-L5 transforaminal injection and a left sacroiliac joint injection by Dr.. A follow-up visit was performed on 08/26/2010 complaining of left SI joint and left L4-L5 transforaminal injections received 1-1/2 to 2 weeks ago. Dr. stated the patient had a return of his current pain pattern set up for a tertiary injection.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

Based on AMA guidelines, the request for injection does not meet guidelines and there is no evidence of motor weakness to substantiate radiculopathy. A 5/5 motor strength is documented for all muscle groups tested post 2 injections. There is a negative straight leg raise. Gait and station are normal. There is no evidence of L5 radicular symptomatology in the patient, only some very soft findings of EMG perispinal increased activity. Therefore there is no evidence of right L4-L5 radiculopathy and requests do not meet ODG guidelines for a bilateral L4 epidural steroid injection at this time.

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 KNOWLEDGBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)