

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** MAY 16, 2011

**IRO CASE #:**

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

Medical necessity of proposed Lumbar Caudal ESI (62311, 77003)

**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 Orthopedic surgery 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:

- XX 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
847.2, 722.10, 724.4	62311		Prosp	1					Upheld
847.2, 722.10, 724.4	77003		Prosp	1					Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant is a gentleman who injured his lower back while working. The patient had fallen backwards, landing across his back on a metal bar of the bucket in his work. He had 80% low back pain and 20% right leg pain radiating down the gluteal region per Dr. This evaluation on

03/03/2011 also noted the patient was diabetic on Glyburide and Metformin. The patient was also an occasional smoker.

The neurological exam showed the patient had intact deep tendon reflexes 2+ at the knee and Achilles. There was some decrease of light touch on the right lower extremity along the lateral shin. His strength was considered to be 5/5 except for the gastrocnemius on the right at 4+ on a scale of 5. The patient underwent 4 sessions of therapy at. An MRI of the lumbar spine was completed on 12/18/2010 and read by Dr., M.D. This showed a 2-3 mm right pericentral disc substance protrusion/herniation with substance contacting the thecal sack without indentation.

The patient had preauthorization denials of the caudal epidural steroid injection by Dr., M.D. who noted that the patient did not have an adequate trial of therapy. The patient did not have any frank nerve root impingement noted on the MRI study. A subsequent preauthorization review for caudal ESI was performed by Dr., M.D. The request was also denied based on ODG criteria.

On 4/20/2011 Dr. noted the patient to still be symptomatic with approximately 80-90% low back pain and 10-20% right leg pain. There were no new neurological findings. The patient had (by his report) decreased strength of the gastrocnemius on the right; however, no calf atrophy or size measurements were reported.

**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/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

The MRI does not correlate with any type of nerve root pressure onto the L5 or S1 nerve root to validate the use of this ESI treatment for the lumbar spine as there is lack of correlation of the imaging study and the reported neurological exam. There was no reflex change. There was no calf measurement reported that would correlate with the reported weakness of the gastrocnemius as well. The patient is also at some increased risk being a diabetic with use of any type of steroid medication which can cause blood sugar variability. The ODG does not support this request as a medical necessity.

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

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES