Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 05/25/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4-L5, L5-S1 Lumbar ESI, Epidural Lysis, Fluoroscopy, Epidurography

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

Board Certified in Physical Medicine and Rehabilitation

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, L5-S1 Lumbar ESI – UPHELD
Epidural Lysis – UPHELD
Fluroscopy – UPHELD
Epidurography – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Employer's First Report of Injury or Illness, 06/17/08
- Evaluation, Clinic, 06/17/08, 06/30/08
- DWC Form 73, Clinic, 06/30/08
- Initial Consultation, M.D., 12/24/08
- Consultation, Dr. 01/07/09, 03/07/09, 05/06/09, 06/10/09, 07/15/09, 08/19/09, 09/21/09, 10/26/09, 12/11/09, 01/15/10, 02/22/10, 03/17/10, 05/05/10, 06/11/10, 07/14/10, 08/16/10, 09/22/10, 10/27/10, 12/10/10, 03/31/10
- Imaging Report, M.D., 02/02/09
- Physical Therapy, Pain Recovery, 02/02/09, 02/06/09, 02/09/09, 02/11/09, 02/13/09, 02/16/09, 02/18/09, 03/09/09, 03/11/09, 03/13/09, 03/16/09, 03/24/09
- Designated Doctor Examination (DDE), D.O., 02/05/09, 09/14/09, 11/10/10
- Orthopedic Consult, M.D., 05/01/09, 08/16/10, 03/14/11
- Medical Report, D.C., 06/10/09
- Consultation and Letter of Medical Necessity for Lumbar ESI, M.D., 06/16/09
- Request for Clarification, Dr. 07/13/09
- Response to Request for Clarification, Dr. 07/29/09
- Chronic Pain Program, Pain Recovery 08/31/09, 09/09/09, 09/10/09, 10/06/09, 10/07/09, 10/13/09, 10/14/09, 10/15/09, 10/20/09, 10/21/09, 10/22/09, 10/26/09, 12/01/09, 12/02/09, 12/07/09, 12/08/09, 12/09/09, 12/11/09, 12/14/09, 12/15/09, 12/16/09, 12/17/09
- Mental Health Evaluation, M.Ed., L.P.C., 09/10/09
- Discharge Summary, Ms. 09/10/09
- Work Capacity Evaluation, Functional Testing, 09/15/09
- Designated Doctor Dispute, Dr. 10/09/09
- Functional Capacity Assessment, Functional Testing, 02/26/10
- Imaging Report, Imaging Center, 05/24/10, 06/11/10
- Independent Medical Examination (IME), M.D., 06/28/10
- Computerized Muscle Testing and Range of Motion Testing, Allied Diagnostics, 08/06/10, 03/14/11
- Initial Medical Report, M.D., 01/17/11
- Electormyographic Examination, M.D., 01/25/11
- Evaluation, Dr. 02/18/11, 03/22/11
- DWC Form 73, Dr. 02/18/11, 04/29/11
- Denial Letter, 03/25/11, 03/30/11, 05/03/11
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was injured on xx/xx/xx when she injured her neck and lower back. She was initially treated at the Clinic and placed on oral medications and returned to work on modified duty. She had participated in a home exercise program. An MRI of the lumbar spine revealed a disc protrusion with annular tear at L4-L5 and central disc protrusion at L5-S1 slightly off the midline towards the left. There was a 1.5 mm lateral meningocele at L5-S1 bilaterally. The patient was maintained on Ultracet, Mobic, and Skelaxin by Dr.

A mental health evaluation was performed and it was recommended the patient undergo ten sessions of a pain management program, which she completed on 09/10/09. Cymbalta was later added to the patient's medication regimen, as well as Hydrocodone and Zanaflex. An MRI of the cervical spine revealed minimal disc bulge centrally at the C3-C4 and C5-C6 levels. There was a small centrally disc protrusion/ herniated disc at the C4-C5 level. An additional MRI of the lumbar spine was performed, which revealed a 3 mm broad-based disc protrusion at the L5-S1 level with anterior displacement of the S1 nerve roots on the left. There was also a 2 mm disc bulge with paracentral annular tear at the L4-L5 level on the left. There was minimal disc bulge at L3-L4. An EMG showed mild to moderate distal sensorimotor exonal peripheral polyneuropathy of the peroneal nerve. There was no definite electrodiagnostic evidence of tibial neuropathy or saoral plexopathy or lumbosacral radiculopathy. A lumbar epidural steroid injection (ESI) was recommended.

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

The proposed treatment is not either reasonable or necessary per the ODG. This is a patient who sustained a pushing/pulling injury to the lumbar spine during the course of her employment. The initial diagnosis was for a lumbar sprain/strain and an MRI documents mild disc protrusion at L4-L5 and L5-S1, which demonstrates no evidence of acute nerve root compression. Electrodiagnostic testing documents peripheral polyneuropathy, but no evidence of active radiculopathy. There are also no specific physical examination findings documented which are compatible with lumbar radiculopathy. As such, the patient does not meet the ODG criteria for performance of lumbar epidural steroid injection. The remaining requested procedures are part and parcel of the original procedure; therefore, none of the requested treatments would be reasonable and necessary.

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)**

☐ **AMA GUIDES 5TH EDITION**