



3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069  
Ph 972-825-7231 Fax 972-274-9022

---

### **Notice of Independent Review Decision**

**DATE OF REVIEW:** 4/29/2011

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of lumbar epidural steroid injection at L4-5 with fluoroscopy.

**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 lumbar epidural steroid injection at L4-5 with fluoroscopy

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This medical record presents little information regarding this individual's injury or subsequent treatment. The reported injury date is, but there is no description of the injury or any post injury care. The first note for review was dated March 15, 2011 and was from M.D. In that note, Dr. documented that the individual had a left psoas compartment plexus block on July 21, 2010 with 80% improvement in back and left lower extremity symptoms which lasted three months. Dr. note said that in the "past couple of months" the pain had returned to the back and both lower extremities. Dr. reported that the individual was complaining of numbness and tingling in both lower extremities and stated that Norco was not providing much in the way of relief.

Dr. examination indicated that the injured worker had an antalgic gait. He had active muscle spasms as well as trigger points in the right quadratus lumborum, gluteus medius, and gluteus maximus muscles. Decreased range of motion of the lumbar spine was described. Dr. further stated that the individual had "numbness and tingling to the left lower extremity with light touch on examination." There was no documentation of dermatomal sensory loss, reflex change, or myotomal weakness. Straight leg raising was not addressed. Dr. stated that his diagnosis included failed back syndrome and return of lower back pain with left-sided radiculopathy. He recommended two lumbar epidural steroid injections, trigger point injections, and Toradol 60 mg intramuscularly.

This medical record contains two letters of denial for the lumbar epidural steroid injections, the first dated March 21, 2011 and the second dated April 4, 2011.

On April 6, 2011, M.D. performed electrodiagnostic studies including EMG and nerve conduction studies. The needle examination was said to show increased duration motor units in the right peroneous longus, slightly increased spontaneous activity in the right mid-lumbar paraspinal muscles, and moderately increased spontaneous activity in the left mid-lumbar paraspinal muscles. Conclusions were that the electrodiagnostic studies were "suggestive of bilateral mid-lumbar radiculopathy" and neuropathy, possibly secondary to diabetes.

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

The requested service is denied. Limited medical records on this injured worker are available for review. The treating physician has recommended lumbar epidural steroid injections. The only mention of previous treatment was a left psoas compartment plexus block on July 21, 2010. There is no indication that the individual has received physical therapy, exercises, nonsteroidal anti-inflammatory drugs, muscle relaxants, or any other treatment modalities. The physical examination described on this individual is not consistent with radiculopathy. There is a statement that the individual has muscle spasms, trigger points, an antalgic gait, decreased range of motion of the lumbar spine, and apparently, nondermatomal sensory loss

in the left lower extremity described as “numbness and tingling in the left lower extremity with light touch on examination.” Electrodiagnostic studies reportedly showed “increased spontaneous activity” in the mid lumbar paraspinal muscles bilaterally and increased duration motor unit action potentials in the right peroneous longus muscle. There was no other indication of abnormality on needle electrodiagnostic exam.

According to the American Association of Electrodiagnostic Medicine Mini Monograph Number 32, “The electrodiagnostic examination in patients with radiculopathies,” EMG abnormalities reported in this report are not diagnostic of radiculopathy. Spontaneous activity in paraspinal muscles alone is not diagnostic of radiculopathy. This can be seen in up to 48% of normal individuals studied. Increased spontaneous activity including fibrillation potentials in the paraspinal muscles are not pathognomonic of radiculopathy and are frequently found in individuals with diabetes mellitus. The Mini Monograph states that “a study is considered positive for radiculopathy if abnormalities are present in two or more muscles that receive enervation from the same root, preferably via different peripheral nerves, but are not detected in muscles enervated by the normal roots adjacent to the involved one.”

Because there is no objective finding on physical examination that would document a radiculopathy and there is no corroborative evidence of radiculopathy on imaging studies or electrodiagnostic testing, this injured worker does not meet criteria for diagnosis of a radiculopathy. Also, there is no indication that the individual’s problem was unresponsive to usual conservative treatment for back and lower extremity pain such as exercises, physical therapy, nonsteroidal anti-inflammatory drugs, and muscle relaxers. Criteria for lumbar epidural steroid injections as set forth in the ODG Treatment Guidelines are not met in this injured worker.

References included:

1. AAEM Mini Monograph Number 32: “The electrodiagnostic examination in patients with radiculopathies”
2. ODG Treatment Guidelines.

**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)**

References also included: AAEM Mini Monograph Number 32: "The electrodiagnostic examination in patients with radiculopathies"