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Notice of Independent Review Decision

DATE OF REVIEW: 11/18/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Transforaminal epidural steroid injection (ESI) on the right at L4-L5 and L5-S1

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

Board Certified in Orthopedic Surgery

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.

Transforaminal ESI on the right at L4-L5 and L5-S1 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY

On 11/16/10, the unknown physician at Texas Orthopaedics & Sports Medicine diagnosed the patient with low back and lumbar radiculopathy. An MRI was recommended and performed on 12/02/10. At L2-L3, there was a minimal disc bulge with no neural encroachment. At L4-L5, there was a diffuse bulge with moderate narrowing of the inferior aspects of the neural foramina bilaterally. There was an annular rent in the foraminal distribution leftward with moderate facet arthropathy. At L5-S1, there was slight retrolisthesis of L5 on S1 with the diffuse disc bulge abutting, but not effacing the ventral thecal sac. Narrowing of the inferior aspects of the neural foramina bilaterally with mild rightward and minimal on the left was noted. On 12/06/10, the unknown physician reviewed the MRI and physical therapy was recommended, as well as a consultation with Dr. for possible lumbar ESIs. Dr. recommended an EMG/NCV study on 12/14/10 and possible ESIs. The EMG/NCV study was performed on 02/22/11

and revealed no electrodiagnostic evidence of right lower extremity radiculopathy, lumbosacral plexopathy, or isolated tibial or peroneal mononeuropathy. Dr. recommended a right L5-S1 ESI based on the MRI. Dr. performed right L4-L5 transforaminal ESIs on 04/08/11 and 08/19/11. The patient informed Dr. on 05/04/11 that we had complete resolution of this right lower extremity pain with some residual low back pain. Dr. noted the patient might benefit from a facet joint block in the future. On 06/22/11, the patient noted he still had complete resolution of his right lower extremity pain, but he still had generalized low back pain that limited his physical therapy. Dr. recommended bilateral L4-L5 and L5-S1 facet joint blocks, which were performed on 07/08/11. The patient informed Dr. on 08/01/11 that his back pain was 50% improved following the facet blocks, but his right lower extremity pain and numbness had returned. Dr. recommended a second right L4-L5 transforaminal ESI. The patient returned to Dr. on 09/07/11, noting complete resolution of his right lower extremity pain following the most recent ESI, but he still noted some back pain. Dr. did not feel at that time a third ESI was necessary until his pain returned and they wanted to fall back on a third injection, if needed. On 10/05/11, Dr. recommended a right L4-L5 and L5-S1 transforaminal ESI. On 10/13/11 and 10/24/11, provided notices of adverse determinations for transforaminal ESI on the right at L4-L5 and L5-S1.

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

The requested transforaminal ESI on the right at L4-L5 and L5-S1 does not meet the criteria from the ODG. This patient has had a multitude of injections, including two prior transforaminal ESIs and facet injections. His pain has centralized and he has at this time no subjective radicular pain complaints as required by the ODG. Further, his neurological examination is normal and he has had a normal EMG/NCV study. At the current time, he does not meet the criteria of the ODG, which the criteria for repeat injections include documentation as to the duration of relief and the presence of radicular signs and symptoms. It does not appear at this time that the patient has any objective evidence of radiculopathy. Therefore, the requested transforaminal ESI on the right at L4-L5 and L5-S1 is neither reasonable nor necessary and the previous adverse determinations should be upheld 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 AND KNOWLEDGE BASE
- 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)**