

# Applied Resolutions LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Oct/05/2011

**IRO CASE #:**

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

Transforaminal ESI Right L5/S1, Nerv Root Sheath Injection Left S1

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

Anesthesiology

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Preauthorization review 08/22/11

Preauthorization reconsideration / appeal request review 09/15/11

Reconsideration request letter Ruben Villegas 09/06/11

CT myelogram lumbar spine 07/29/11

CT scan lumbar spine 08/23/10

X-rays 3 views lumbar spine 08/16/10

EMG/NCV 05/19/11

Office visit notes Dr. 09/01/11, 06/20/11 and 05/10/11

Office note Dr. 04/22/11

Functional capacity evaluation 02/24/11

Designated doctor evaluation Dr. 04/18/11

Office notes Dr. 11/03/10-01/26/11

Physical therapy evaluation and progress notes 11/10/10-01/28/11

Chiropractic notes

Levelland Clinic physician records 08/16/10-02/07/11

**PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a male whose date of injury is xx/xx/xxxx. Records indicate he was installing mud flap on his truck when he experienced low back pain radiating to left lower extremity. He has remote history of L3-4 fusion in 1999. CT scan of lumbar spine performed 08/23/10 revealed postoperative changes at L3-4. Fusion looks solid. At L4-5 there is a 3.5 mm diffuse disc bulge abutting the 4th lumbar nerve root. At L5-S1 there is a 3 mm diffuse

disc bulge abutting the first sacral nerve root. No central canal stenosis is identified. Electrodiagnostic testing performed 05/19/11 was reported as normal study without evidence of peripheral neuropathy, entrapment neuropathy, radiculopathy, or other neuromuscular disease of left leg. A CT myelogram was performed on 07/29/11 and reported L3-4 fusion with laminectomy; mild to moderate L4-5 stenosis; bulging disc T12-L1. The injured employee was seen by Dr. who recommended the injured employee undergo transforaminal epidural steroid injection on right at L5-S1 and nerve root sheath injection left S1.

A preauthorization request for transforaminal epidural steroid injection right L5-S1, nerve root sheath injection left S1 was reviewed on 08/22/11 and determined the clinical findings do not appear to support medical necessity of treatment requested. It was noted that the claimant was injured from working on mud flap of truck and initially with low back pain then radiating to left lower extremity. He is status post treatment with physical therapy, medications, activity modification. It was noted there was no clear mention of right leg symptoms or findings. There was mention of decreased sensation in left L5 pattern. EMG/NCV on 05/19/11 was normal. It was also noted that CT scan of lumbar spine on 08/23/10 mentioned abutment but not clear neuro compression. It was noted the request was not consistent with ODG criteria regarding epidural steroid injection to low back.

A reconsideration / appeal request for transforaminal epidural steroid injection right L5-S1, nerve root sheath injection left S1 was reviewed on 09/14/11, and the original determination was upheld, and certification was not recommended for proposed procedure. Non-certification rationale was based on the following reasons: 1) the most recent examination on 06/20/11 did not clearly demonstrate objective findings consistent with focal neurologic deficit in dermatomal or myotomal pattern that would cause concern for active radiculopathy stemming from lumbosacral spine. In absence of radiculopathy, the claimant would not be considered and appropriate candidate for requested injection; 2) the electrodiagnostic study of left lower extremity was normal and did not show evidence of left sided radiculopathy; 3) the 06/20/11 visit did not establish current complaints of right lower extremity radicular symptoms. It is noted that ODG criteria for epidural steroid injections require radiculopathy must be documented and present on examination.

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

The proposed transforaminal epidural steroid injection right L5-S1, nerve root sheath injection left S1 is not supported as medically necessary by clinical data submitted for review. The claimant sustained an injury to low back while installing mud flap to work truck. He subsequently developed radiating pain to left lower extremity. The records reflect that the claimant had previously undergone L3-4 fusion in 1999. EMG/NCV performed on 05/09/11 was reported as normal study without evidence of radiculopathy or any other neuromuscular disease of left leg. The most recent imaging study was CT myelogram performed on 07/29/11 which revealed postoperative changes of L3-4 fusion with laminectomy. It was noted there was facet arthrosis combined with ligamentum flavum hypertrophy, facet spurring / small ossicles on left and generalized bulging of annulus fibrosis results in mild to moderate stenosis at L4-5 with AP canal diameter measuring about 1 cm. The disc bulging is more prominent towards the right. No additional disc herniation / stenosis is seen. The injured employee's symptomatology is noted to be primarily to left leg, but disc bulging is more prominent to the right. There is no clear evidence of radicular symptoms on clinical examination with no motor or sensory changes reported. Per ODG guidelines, criteria for use of epidural steroid injections requires that radiculopathy must be documented by objective findings on examination and corroborated by imaging studies and / or electrodiagnostic testing. Based on the clinical information provided, ODG criteria are not met, and medical necessity is not established for the proposed transforaminal epidural steroid injection right L5-S1, and nerve root sheath injection left S1.

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

ACOEM-AMERICA 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)