



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 08/31/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Epidural Steroid Injection at L4-L5

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.

Lumbar Epidural Steroid Injection at L4-L5 – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Right Wrist X-Rays, M.D., 05/26/10
- Right Elbow X-Rays, Dr. 05/26/10
- Right Shoulder MRI, M.D., 05/26/10

- Right Knee MRI, Dr., 05/26/10
- Right Hip MRI, Dr., 05/26/10
- Consultation, M.D., 06/01/10
- Initial Consultation, M.D., 06/07/10
- Brain MRI, Dr., 06/15/10
- Follow Up, Dr. 06/29/10, 07/14/10
- Physical Therapy Evaluation, 07/12/10, 09/15/10
- Request for Reconsideration, , 07/28/10, 09/29/10
- Orthopedic Consult, M.D., 08/16/10, 09/21/10, 11/04/10, 12/02/10, 01/17/11, 02/01/11, 03/08/11, 04/05/11, 05/17/11, 06/14/11, 07/08/11, 07/22/11
- Consultation, Dr., 10/13/10
- Peer Review, M.D., 10/14/10
- Designated Doctor Evaluation (DDE), D.O., 10/21/10
- Operative Report, Dr., 10/27/10, 03/02/11
- Right Elbow MRI, M.D., 12/22/10
- DDE, M.D., 12/23/10
- Electromyographic Examination, M.D., 12/28/10, 03/29/11
- Manual Muscle Testing (MMT) and Range of Motion (ROM), Dr. 01/17/11, 03/08/11, 04/05/11, 06/14/11
- Right Shoulder X-Ray, Dr., 03/08/11
- Right Knee X-Rays, Dr. , 03/08/11
- Right Pelvis and Hip X-Rays, Dr., 03/08/11
- Lumbar MRI, M.D., 06/16/11
- Denial Letter, 07/21/11, 08/02/11
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was injured when she sustained a fall to her right side. She had complaints in multiple body areas, including her head, right shoulder, low back, right hip and right knee. She had a history of right knee arthroscopy that had been performed on 10/27/10, a right shoulder arthroscopy in March of 2011 and carpal tunnel release in April 2011, with post-operative physical therapy performed. Her current complaints were of low back pain with radiation to the right lower extremity with numbness and tingling. Objective examination noted tenderness and decreased range of motion with a positive straight leg raise. An EMG performed on 03/29/11 showed no definite evidence of lumbar radiculopathy. There were findings consistent with polyneuropathy of the common peroneal nerve. A lumbar epidural steroid injection was recommended.

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

The initial recommendation for non-certification was due to lack of imaging and/or electrodiagnostic evidence, nerve root compromise, and radiculopathy consistent with subjectively reported radicular symptoms. The rebuttal doctor, Dr., noted on 07/22/11, the patient's physical examination findings revealed severe tenderness on palpation with decreased range of motion in all directions, positive straight leg raising on the right but he fails to document whether it reproduced radicular symptoms in a pattern consistent with the reported L5 or S1 distribution. It noted strength was weakened in the entire lower extremity, mostly right hip and right knee flexors and extensors. All of that weakness would not be consistent with the L5 or S1 nerve root distribution, and it would not be considered a focal deficit. Dr. also noted the patient had paresthesias in the lateral aspect of the right lower extremity going to the first digit of the toe consistent with a right L5 distribution, and he is correct that subjective complaint of paresthesias into the lateral aspect of the right lower extremity to the first toe would be in the right L5 distribution. He notes that if Dr. looked at his office visit, there was clearly a dermatomal pattern in which the patient was presenting, but on the 07/08/11 note, the physical examination only states positive straight leg raising right, negative left, does not indicate if there is a dermatomal pattern to the straight leg raising, and the motor strength was mainly right hip and knee flexors and extensors, which is not a focal finding, and the paresthesias is not a physical examination finding but a subjective complaint. The patella was 2+ left, 1+ right, and 1+ Achilles bilaterally, which would be considered a focal finding but would be for an L4 distribution, not for an L5 nor S1. He notes the EMG study while noting no definite lumbosacral radiculopathy did note abnormal needle electrode examination showing chronic denervation potential with reduced interference pattern of the peroneal enervative bilateral leg muscles, distal lower extremity, with relative preservation of the proximal thigh and paraspinal musculature. At this time the medical records are inconsistent for findings that would support a focal finding for neurological deficits that would support the requested epidural steroid injection. Therefore, I recommended non-certification of the requested treatment in line with ODG criteria for lumbar epidural steroid injection.

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**