

SENT VIA EMAIL OR FAX ON  
Sep/06/2011

## True Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/06/2011

**IRO CASE #:**

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

Right L4 and L5 Transforaminal ESI with IV sedation, Contrast, and Fluoroscopy (1)

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

Anesthesiology/Pain Management

**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

1. Cover sheet and working documents
2. X-ray lower spine dated 02/25/11
3. Incomplete report of medical evaluation dated 05/23/11
4. MRI lumbar spine without dye dated 06/14/11
5. Pain management consultation dated 06/22/11
6. Peer review Dr. dated 07/04/11
7. Initial review adverse determination letter dated 07/12/11 for request right L4 and L5 transforaminal ESI with IV sedation, contrast, and fluoroscopy
8. Letter of reconsideration dated 07/15/11
9. Peer review Dr. dated 07/17/11
10. Reconsideration adverse determination letter dated 07/27/11 for appeal request right L4 and L5 transforaminal ESI with IV sedation, contrast, and fluoroscopy
11. Letter of reconsideration dated 08/02/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xxxx. On this date the patient felt pain in her lower back. IME dated 05/23/11 indicates that the patient has completed 6 sessions of physical therapy to date. The report is incomplete as only 5 of 9 pages were submitted for review. MRI of the lumbar spine dated 06/14/11 revealed right paracentral disc herniation at L4-5 with impingement of the right L4 and L5 nerve roots. Physical examination on 06/22/11 notes there is positive double straight leg raising on the right and positive single straight leg

raising for radicular pain in L4 and L5 distributions. There is decreased sensation to pinwheel on the right L5 and S1 dermatomes. Motor strength is severely decreased at right EHL at 3/4, 4/5 to remaining right lower extremity. Deep tendon reflexes are 1+ at the right patella and right Achilles, 2+ on the left.

Initial request for epidural steroid injection was non-certified on 07/12/11 noting that a bilateral lower extremity EMG/NCV was recommended to confirm the presence or absence of radiculopathy. Peer review dated 07/17/11 indicates that the patient does not have any objective dermatomal deficits to match the disc protrusion at L4-5. There is no necessity for any spine surgery or even an epidural steroid injection as she does not have an objective radiculopathy. The denial was upheld on appeal dated 07/27/11 noting that the physical examination findings require clarification. On separate occasions findings have documented decreased strength in the right L5-S1 dermatome and on another occasion in the L4-5 dermatomal region on the right. MRI findings require clarification as initial findings indicated possible impingement of right L4-5; however, on a review by a clinician no significant radiculopathy or impingement of the nerve roots was noted.

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

Based on the clinical information provided, the request for right L4 and L5 transforaminal epidural steroid injection with IV sedation, contrast and fluoroscopy (1) is not recommended as medically necessary, and the two previous denials are upheld. The patient's physical examination findings and MRI findings require clarification. There are conflicting physical examination findings provided, and conflicting interpretations of the MRI report. Peer review dated 07/17/11 reports that the patient does not have any objective radiculopathy, and notes that there is no necessity for any spine surgery or epidural steroid injection. Given the current clinical data, the requested epidural steroid injection is not indicated as medically necessary.

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

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**