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Notice of Independent Review Decision

DATE OF REVIEW: 9-8-2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an intralaminar lumbar epidural steroid injection at L4-L5 and epidurography.

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 intralaminar lumbar epidural steroid injection at L4-L5 and epidurography.

A copy of the ODG was provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, this worker was injured on xx/xx/xxxx. She was lifting a box and felt a sharp pain that radiated down the left side to the knee. Records indicate that two years prior to this injury, the worker had fallen and injured her left knee and hand. The worker was evaluated at an urgent care center on June 29, 2010. She was seen by a physician, Dr. Dr. noted that x-rays of the left hand and knee showed no fracture. A lumbar

x-ray series showed no fracture or disk space narrowing. The evaluating physician's impression was that the injured worker had sustained a lumbar sprain and an old left hand and knee injury. He stated that there were "no objective findings." He recommended a thorough physical therapy functional evaluation and continuation of use of Tramadol and Meloxicam.

A physical therapy evaluation performed on July 2, 2010 revealed that the assessment was consistent with a sprain of the lumbar region and dysfunction of the sacroiliac joints bilaterally. The injured worker continued to receive medical care, initially, directed toward a thoracolumbar strain. A note from the treating physician, M.D. dated July 22, 2010 indicated that the compensable diagnosis pertaining to this injury was thoracolumbar strain.

The injured worker then was seen by different physicians. She initiated treatment with D.C. on November 12, 2010. An MRI of the lumbar spine was performed on February 25, 2011. This demonstrated a post central, left paracentral, and posterolateral broad based disk protrusion measuring 3 millimeters at L4-5 and a posterior central disk protrusion measuring 2 to 4 millimeters at L5-S1. There was no mention of neural foraminal narrowing or nerve root compromise.

On July 6, 2011, the injured worker was evaluated by M.D. for pain management. The note presented for review was written by Nurse Practitioner. It was noted that the injured worker was complaining of low back pain measuring 9 on a scale of 0 to 10 and "tingling" toward the end of the day in both lower extremities. There was pain on palpation over the spine from L3 to S1, 2+ and equal deep tendon reflexes, a sensory deficit in the left L4-5 dermatome, and weakness in the left lower extremity described as "3/5." This finding was generalized and not myotomal or focal weakness. The straight leg raise on the left was said to be positive. A diagnosis of lumbar spine pain with radiculopathy was made. It was recommended that the injured worker take Naproxen, Tramadol, and Soma and undergo a left epidural steroid injection.

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

Recommend denial of requested service. According to available medical records, this worker was injured on June 24, 2010. Records indicate that the injury sustained at that time was to the thoracolumbar spine and fit best in the strain category. The worker received multiple medications and physical and chiropractic therapy. She underwent MRI scanning and was seen and evaluated by a pain management specialist who recommended lumbar epidural steroid injections.

According to ODG Guidelines, criteria for use of epidural steroid injections include a statement that a radiculopathy must be documented. Objective findings on examination need to be present and radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. This record first of all indicates that the initial injury was classified as a thoracolumbar strain with no mention of radiculopathy. Later evaluations began mentioning radiculopathy. Imaging studies showed what appears to be degenerative disk disease at the L4-5 and L5-S1 level, but there was no mention of neural foraminal or nerve root compromise.

No electrodiagnostic studies were reported in this record. Examination findings are not diagnostic of radiculopathy, at least those presented in this record. Deep tendon reflexes were said to be active and equal. There was a sensory decrease in the L4, L5 distribution

and straight leg raising was said to be positive at 60° on the left. Manual muscle testing, however, revealed generalized weakness in the left lower extremity, not weakness limited to a myotomal distribution. Although this injured worker has not been responsive to conservative treatment according to the medical record, there is no clear evidence of radiculopathy either on examination, imaging studies, or electrodiagnostic studies. Epidural steroid injections are not recommended for a thoracolumbar strain/sprain.

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 KNOWLEDGBASE
- 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)