

SENT VIA EMAIL OR FAX ON  
Mar/06/2012

## Applied Assessments LLC

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Mar/06/2012

**IRO CASE #:**

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

OP Left L5/S1 Transforaminal ESI with Fluoroscopic

**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

Notification of reconsideration determination 02/20/12

Notification of adverse determination 01/20/12

Fax cover sheet and letter of appeal 01/24/12

MRI lumbar spine 12/08/11

Office notes 01/20/12 and 01/03/12

Progress note 12/12/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male whose date of injury is xx/xx/xx. Records indicate he was at work and felt pulling on his back. He underwent course of physical therapy without significant progress. MRI of lumbar spine was performed on 12/08/11 and revealed central disc protrusion with herniation at L5-S1, with no root displacement. The claimant was seen on 01/03/12 with chief complaint of low back pain and left lower extremity pain. The patient was noted to be taking Ibuprofen 800 mg as needed for severe pain. Physical examination noted the claimant to be 5'6 1/2" tall and 180 lbs. Lumbar spine examination noted that on range of motion testing flexion produces moderate pain radiating down left lower extremity. Extension produces moderate pain radiating down left lower extremity. Lateral rotation was negative. Kemp's test was negative. Straight leg raise was reported as positive at L5-S1 dermatomal distribution. Slump was positive for the same. MRI was reviewed by and noted to show L5-S1 central disc protrusion with herniation and nerve root displacement. There was mild right and moderate left foraminal stenosis and moderate facet osteoarthritis. The claimant was

recommended to undergo left L5-S1 transforaminal epidural steroid injection.

A utilization review performed on 01/20/12 determined the request for left L5-S1 transforaminal epidural steroid injection with fluoroscopic guidance to be non-certified as medically necessary. It was noted per latest medical report dated 01/03/12 the claimant presented with low back pain and left lower extremity pain. Physical examination showed positive straight leg raise test at L5-S1 dermatomal distribution. Manual muscle testing, sensory examination and deep tendon reflexes were not documented. Findings on MRI report are noted. It doesn't show nerve root compression or spinal/foraminal stenosis to corroborate with symptoms. It was noted the claimant has attended physical therapy, but no therapy progress notes were provided that objectively documented the claimant's clinical and functional response to therapy. There also is no indication that requested injection would be used as adjunct to facilitate progress in more active treatment programs.

A reconsideration / appeal request for left L5-S1 transforaminal ESI with fluoroscopic guidance was reviewed on 02/20/12 and the previous adverse determination was upheld. The reviewer noted the claimant complains of low back pain and left lower extremity pain. MRI showed a central disc protrusion at L5-S1 with no root displacement. On examination there are no motor, sensory or reflex changes. Straight leg raise was positive at L5-S1 dermatomal distribution. Slump test was positive for same. Noting that there is no evidence of neurocompressive pathology on MRI, and noting that physical examination did not strongly demonstrate radicular findings, medical necessity was not established for left L5-S1 transforaminal epidural steroid injection.

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

The clinical data submitted for review does not support determination of medical necessity for proposed left L5-S1 transforaminal epidural steroid injection with fluoroscopic. The claimant is noted to have sustained lifting injury to low back on 10/18/11. Records indicate the claimant was discharged from physical therapy due to not making any further progress after 9 treatments; however, no therapy notes were submitted for review with documentation of the modalities used and response to treatment. MRI of lumbar spine revealed L5-S1 central disc protrusion with herniation with mild right and moderate left foraminal stenosis. Although review of MRI indicated there was nerve root displacement, the radiology report specifically indicates no root displacement. Clinical examination reported no evidence of motor, sensory or reflex changes. Straight leg raise was reported as positive at L5-S1 dermatomal distribution, but there is no indication what degree straight leg raise became positive, and if this was positive for low back pain only or included pain radiating down the lower extremities. Per ODG guidelines, criteria for epidural steroid injection require that radiculopathy must be documented with objective findings on examination, and radiculopathy must be corroborated by imaging studies and / or electrodiagnostic testing. The clinical data presented does not clearly demonstrate objective findings of radiculopathy on examination. There is also no clear evidence of neurocompressive pathology on MRI scan. Consequently, the proposed transforaminal ESI is not recommended as medically necessary. Previous denials were correctly determined and should be upheld on IRO.

**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)