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Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Notice of Independent Review Decision

**Date notice sent to all parties:** 09/21/12

**IRO CASE #:**

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

Bilateral L4 transforaminal epidural steroid injection (ESI)

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

Board Certified in Orthopedic Surgery  
Fellowship Trained in Spinal 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 medical necessity exists for each of the health care services in dispute.

Bilateral L4 transforaminal ESI - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

Reports from M.D. dated 03/11/11, 03/15/11, 04/18/11, 05/16/11, 01/17/12, 02/15/12, 06/29/12, and 07/30/12  
X-rays of the lumbar spine dated 03/11/11  
Lumbar MRI dated 03/21/11 and interpreted by M.D.  
Therapy evaluation and plan of care dated 05/17/11 from P.T.  
Prescription for a TENS unit dated 05/17/11  
A request to continue therapy dated 05/24/11  
Risk Management Fund notices dated 06/02/11  
Report from M.D. dated 08/20/12  
notices of adverse determinations dated 08/20/12 and 08/31/12  
Requests for lumbar epidural steroid injection (ESI) dated 08/23/12 and 09/10/12  
Preauthorization notices from dated 08/24/12 and 09/10/12  
Letter from Dr. dated 08/31/12  
Prospective IRO response dated 09/17/12  
The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

On xx/xx/xx, Dr. noted the patient injured his lower back at work. He had normal range of motion and strength on exam. The diagnoses were low back pain and muscle spasm. Hydrocodone/APAP and Amrix were prescribed. X-rays of the lumbar spine on 03/11/11 showed mild disc space narrowing at L4-L5 and L5-S1 with mild dextroscoliosis. A lumbar MRI on 03/21/11 revealed circumferential disc bulging at L4-L5 and L5-S1 and posterior central disc/broad based small protruded disc indenting on the thecal sac. There was degenerative disc disease and facet joint arthropathy and minimal, not significant, relative spinal canal stenosis at L5-S1 and slight foraminal stenosis at L4-L5. Dr. reexamined the patient on 05/10/11 and the patient noted his strength had decreased. Range of motion was normal, as was his strength on exam. It was noted he would have his last therapy session the following day and Dr. recommended a home program. He was asked to return in two to four weeks in the hopes he could release to full duty. On 01/17/12, Dr. documented lumbar flexion at 122 degrees and extension at 15 degrees. Lortab was refilled. On 06/29/12, he had normal lumbar range of motion and no radiculopathy was documented. He was asked to return in one month and his medications were refilled. Dr. reexamined the patient on 07/30/12 and his exam was unchanged. He was referred to pain management. Dr. examined the patient on 08/20/12. He had stiffness and muscle spasms. He denied major motor weakness or saddle anesthesia. He had pain over the left lumbar paraspinal muscles and left posterior iliac crest. He had full active range of

motion. Strength was 5/5 throughout and DTRs were 2/4 in the bilateral Achilles' and patellar reflexes. Bilateral Kemp's, straight leg raising, and Faber's testing was negative. The assessment was a lumbar disc bulge. Dr. noted the patient had low back pain with no radiation of the pain to the lower extremities and the patient had no weakness or numbness to the lower extremities. He recommended a bilateral L4 transforaminal ESI. On 08/20/12 and 08/31/12, provided letters of non-authorization regarding the requested bilateral L4 transforaminal ESI. Dr. wrote a letter on 08/31/12 noting he was unable to reproduce his pain on examination and he felt he would benefit from a bilateral transforaminal L4 ESI.

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

The requestor, Dr., states he is unable to reproduce the patient's pain. On that basis, he has requested an ESI. However, there is no indication in the medical records of any objective findings of radiculopathy. In fact, Dr. notes in his chart note that the patient has no radiation of pain to the lower extremities. He also noted the patient had no weakness or numbness to the lower extremities. ESIs are not recommended for axial/discogenic pain and the patient does not meet the criteria for ESIs per the recommendations of the ODG. The first criteria in the ODG for ESIs is the objective documentation of radiculopathy. As noted, he does not have any evidence of radiculopathy, which Dr. notes. The ODG notes in regard to the transforaminal approach that there may be a preference for a transforaminal approach as the technique allows for delivery of medication at the target tissue site and an advantage for transforaminal injections in herniated nucleus pulposus over translaminar or caudal injections has been suggested in the best available studies. ([Riew, 2000](#)) ([Vad, 2002](#)) ([Young, 2007](#)) This approach may be particularly helpful in patients with large disc herniations, foraminal stenosis, and lateral disc herniations. Based on the MRI reviewed, there were no large disc herniations, but findings of degenerative disc disease and facet joint arthropathy. There was noted to circumferential bulging disc at L4-L5 and L5-S1. Therefore, the requested bilateral transforaminal L4 ESI is not appropriate per the recommendations of the ODG and the previous adverse determinations should be upheld at this time.

**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)**