

# True Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Oct/28/2013

### IRO CASE #:

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

Lumbar Transforaminal Epidural Steroid Injection L5

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

Board Certified PM&R  
Board Certified Pain Medicine

### 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:

ODG - Official Disability Guidelines & Treatment Guidelines  
Utilization review determination dated 09/05/13, 08/29/13  
Office note dated 08/23/13, 08/20/13, 08/07/13, 08/05/13, 07/17/13\  
Physical therapy evaluation dated 07/18/13  
Physical therapy re-evaluation dated 08/16/13, 08/02/13  
Physical therapy daily note dated 08/19/13, 08/06/13, 05/30/13  
MRI lumbar spine dated 07/26/13  
Appeal letter dated 09/03/13  
Letter dated 08/27/13  
PT/OT preauthorization request form dated 08/21/13, 08/07/13, 07/18/13

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. The patient states he felt a sharp pain in his lower back after bending over. The patient underwent a course of physical therapy. MRI of the lumbar spine dated 07/26/13 revealed at L4-5 there are mild anteriorly and laterally directed vertebral body margin osteophytes. There is mild disc bulging. The changes encroach upon the neural foramina on the left, but there is no neural foraminal, lateral recess or central spinal stenosis. At L5-S1 there are minimal anteriorly directed vertebral body margin osteophytes; there is mild facet osteoarthritis on the right. There is no stenosis. Physical examination on 08/23/13 indicates that there is tenderness off lumbar midline only on the left in the paraspinous muscles. Range of motion is flexion full to 75 degrees, extension full and asymptomatic to 25 degrees. Muscle strength is normal. Reflexes are normal. Sensation is normal. Straight leg raising is positive on the left.

Contralateral straight leg raising is asymptomatic bilaterally.

Initial request for lumbar transforaminal epidural steroid injection L5 was non-certified on 08/29/13 noting that it is not clear as to what previous diagnostic workup has been done since the work injury including the results and how this correlates with the physical examination findings in determining whether an objective lumbar radiculopathy is occurring or not at a specific level to support the need for the requested epidural steroid injection. The denial was upheld on appeal dated 09/05/13 noting that the patient has subjective L5 pain with objective findings of numbness in L5 distribution and a positive straight leg raising, but while the MRI notes a disc bulge there is no documentation of impingement of the L5 nerve root that would support the epidural steroid injection as medically necessary within ODG recommendations.

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

The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results prior to the performance of a lumbar epidural steroid injection. The patient's physical examination fails to establish the presence of active lumbar radiculopathy with intact motor, sensation and deep tendon reflexes. The submitted lumbar MRI fails to document any significant neurocompressive pathology. As such, it is the opinion of the reviewer that the request for lumbar transforaminal epidural steroid injection L5 is not recommended as medically necessary.

**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 KNOWLEDGBASE

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)