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## **Notice of Independent Review Decision**

**Review Outcome:**

**A description of the qualifications for each physician or other health care provider who reviewed the decision:**

Neurosurgeon

**Description of the service or services in dispute:**

Lumbar Epidural Steroid Injection Right L4-L5

**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)

**Patient Clinical History (Summary)**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was hit in the back. Lumbar MRI dated 09/30/14 revealed at L4-5 there is mild to moderate circumferential disc bulge and moderate facet and ligamentous hypertrophy causing mild central canal, moderate right foraminal and mild to moderate left foraminal narrowing. Note dated 11/21/14 indicates that he has not undergone physical therapy yet. Medications are listed as naproxen, Flexeril and Tramadol. On physical examination the patient has full range of motion of the upper and lower extremities. Gait is normal. Strength is full in the upper and lower extremities. Straight leg raising is negative. Faber's is negative. There is symmetric sensation to the lower extremities to light touch. Impression is lumbar back pain. Physical therapy discharge summary dated 01/07/15 indicates that the patient states he was feeling pain free with all daily activities and movements. Follow up note dated 01/17/15 indicates that the patient reports 60% relief after therapy. Office visit note dated 01/30/15 indicates that he continues to complain of back pain radiating into the lateral hip and thigh. The patient has completed 6 physical therapy visits with little to no relief. On physical examination straight leg raising is negative. Strength is full throughout. Sensation is symmetric to the lower extremities to light touch. He has no focal weakness in the lower extremities.

Initial request for lumbar epidural steroid injection right L4-5 was non-certified on 01/26/15 noting that note dated 01/05/15 indicates that the patient presents for his fourth physical therapy treatment. He states that over 95 percent of the time he is pain-free. He is no longer taking any pain medication. The patient's physical examination fails to establish the presence of active lumbar radiculopathy as required by the Official Disability Guidelines noting negative straight leg raising, symmetric sensation to the lower extremities to light touch and 2+ deep tendon reflexes. There are no imaging studies/electrodiagnostic results submitted for review. The denial was upheld on appeal dated 02/17/15 noting that the physical examination did not illustrate the presence of radicular findings nor did the MRI reveal neurocompression.

***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

The patient sustained injuries on xx/xx/xx and subsequently completed 6 physical therapy visits. Physical therapy discharge summary dated 01/07/15 indicates that the patient states he was feeling pain free with all daily activities and movements. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's serial physical examinations note that there are no sensory or motor deficits in a dermatomal or myotomal distribution. Deep tendon reflexes are symmetrical and straight leg raising is negative. Therefore, ODG criteria are not met and epidural steroid injection is not medically necessary. As such, it is the opinion of the reviewer that the request for lumbar epidural steroid injection right L4-5 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 and Environmental Medicine um
- knowledgebase AHCPH-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical Literature (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)