

**True Decisions Inc.**  
**An Independent Review Organization**

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**Notice of Independent Review Decision**

Case Number:

Date of Notice: 06/04/2015

**Review Outcome:**

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

Anesthesiology

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

Lumbar transforaminal epidural steroid injection left L5 and S1

**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/x. The patient was moving heavy glass and felt a pain in his lower back. MRI of the lumbar spine dated 02/27/15 revealed at L5-S1 there is focal leftward disc herniation measuring approximately 6 mm with moderate left lateral stenosis. There is moderate posterior displacement of the traversing left S1 nerve roots. Follow up note dated 03/09/15 indicates that pain to the low back remains, but has improved slightly. Current medication is atenolol. On physical examination range of motion remains the same. Deep tendon reflexes are normal. Sensation is normal. Muscle strength is decreased. Straight leg raising is positive bilaterally. Diagnosis is left displacement of lumbar intervertebral disc without myelopathy; left sprain of lumbar. The patient was recommended to continue physical therapy and referred for an epidural steroid injection. Office visit note dated 03/17/15 indicates that previous treatments include 12 sessions of physical therapy with no benefit. He is currently working light duty. On physical examination there is plantar flexion weakness in the left lower extremity. Left L5-S1 dermatomal distribution sensation is reduced to light touch. A request for left L5-S1 lumbar transforaminal epidural steroid injection was authorized on 03/24/15. The patient underwent left L5-S1 lumbar transforaminal epidural steroid injection on 03/27/15. Progress note dated 04/14/15 indicates that he reports 25% improvement after the injection. He continues to work full time. Initial request for lumbar transforaminal epidural steroid injection left L5 and S1 was non-certified on 04/24/15 noting that a review of submitted report indicates that the patient has been diagnosed with moderate left lateral stenosis and he reported a 25% improvement of pain as a result of the first epidural steroid injection on March 27, 2015. Without evidence of at least 50-70% improvement, a repeat epidural steroid injection is not supported at this time. The denial was upheld on appeal dated 05/08/15 noting that documentation indicated that the patient received 25% improvement from the transforaminal epidural steroid injection performed on 03/27/15, and there was a lack of documentation as to the length of time that 25% pain relief lasted.

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

The patient underwent initial left lumbar transforaminal epidural steroid injection at L5-S1 on 03/27/15. Progress note dated 04/14/15 indicates that he reports 25% improvement after the injection. The

Official Disability Guidelines require documentation of at least 50% pain relief for at least 6-8 weeks prior to the performance of a repeat epidural steroid injection. Given the lack of adequate response to the prior epidural steroid injection, medical necessity is not established in accordance with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for lumbar transforaminal epidural steroid injection left L5 and S1 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 AHCPR-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)