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**Date notice sent to all parties:** 01/15/16

**IRO CASE #:**

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

Bilateral transforaminal epidural steroid injection (ESI) with epidurography at L4-L5 and L5-S1

**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 transforaminal ES) with epidurography at L4-L5 and L5-S1 - Upheld

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient wrote a letter on XX/XX/XX to the IRO representative. She noted that through a benefit dispute agreement, it was settled that she had a 10% impairment rating for the diagnosis of herniated nucleus pulposus at L3-L5 and lumbar radiculopathy at L5-S1. She noted the carrier was now claiming her injury to be a lumbar sprain only. On XX/XX/XX, an IRO decision was provided overturning the denial of a follow-up office visit. Per a TDI – DWC Decision & Order dated XX/XX/XX, the compensable injury for the XX/XX/XX claim did extend to and include L3-L4, L4-L5, and L5-S1 herniated nucleus pulposus with radiculopathy. XX performed an RME on XX/XX/XX. Her last injection was in XX/XXXX and she had not undergone surgery. She

was placed at MMI with a 5% impairment rating. It was noted a request for a repeat MRI had been denied. She was using Flexeril, Ultram, and Norco. DTRs were 2+ in the bilateral lower extremities. Motor examination was 5/5 and sensation was intact bilaterally. There was no evidence of atrophy and straight leg raising was normal. The impressions were L3-L4, L4-L5, and L5-S1 disc protrusions. Conservative treatment for her chronic pain syndrome was recommended. XX felt Flexeril was not supported and Ultram and Norco were appropriate, but should not be increased. It was noted she might require ESIs throughout the year, but a new MRI was not necessary. He also noted the patient was not a surgical candidate. XX performed an RME on XX/XX/XX. She was a one pack per day smoker and was on Tramadol and Zanaflex and working full duty. She was not asked to perform range of motion and she had palpable lumbar spasms. Strength was 5/5 in the bilateral lower extremities and DTRs were 1+ bilaterally. Sitting SLR was 80 degrees on the left and 90 degrees on the right. XX felt the patient had a soft tissue lumbar contusion/sprain as a result of the original injury and noted she had multilevel degenerative disc disease with no evidence at any time of any focal nerve root compression. He felt her pain problem was and always had been at the left SI joint and might well be Bertolotti's syndrome. He felt without evidence of radiculopathy, the ESIs performed were never indicated. XX felt the patient should undergo a diagnostic SI joint injection with additional treatment directed at a Bertolotti's syndrome. XX felt the continued use of Tramadol was appropriate, but Zanaflex was no longer appropriate. A lumbar MRI was obtained on XX/XX/XX and revealed mild degenerative changes and minimal disc bulges from L2-L3 through L4-L5 causing multilevel central canal stenosis with mild to moderate stenosis at L4-L5. There was mild bilateral neural foraminal narrowing present at each level. There was a minimal central disc bulge at L5-S1 that might have minimal causal extrusion and caused mild central canal stenosis. XX examined the patient on XX/XX/XX for her lower back pain radiating down her left lower extremity with an onset date of XX/XXXX when her chair at work had oil on it that leaked out. As she sat down, the chair slipped and she fell backwards onto her buttocks. She noted her pain had progressed since that time and was rated at 6/10. She had pain in the lower back that radiated to all of her toes of the left foot. She was currently on Alprazolam, Esomeprazole, Ondansetron, Pravastatin, Premarin, Promethazine, and Tramadol. She had complaints of numbness, tingling, anxiety, and insomnia. She was 65 inches tall and weighed 175 pounds. She had an antalgic gait and strength was normal in the lower extremities. Sensation was normal. Flexion was 50 degrees and there was bilateral facet joint tenderness from L5-S1. SLR was positive on the left at 30 degrees. The assessments were low back pain, opioid dependence, sciatica, circadian rhythm sleep disorder, and chronic pain syndrome. Cyclobenzaprine, Lyrica, Sinelee, and Tylenol #3 were refilled and a new patient medication agreement was signed. A bilateral transforaminal left L4-L5 and L5-S1 ESI was recommended at that time. On XX/XX/XX, XX provided an adverse determination for the requested lumbar transforaminal ESI with epidurography bilaterally at L4-L5 and L5-S1. On XX/XX/XX, XX provided another adverse determination for the requested lumbar transforaminal ESI with epidurography bilaterally at L4-L5 and L5-S1.

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

ESIs are recommended as a possible option for the short term treatment of acute radicular pain, when used in conjunction with an active rehabilitation effort. It is not recommended for duration of symptoms greater than 24 months, as the success rate is

very small. The ODG does indicate that ESIs are appropriate during the time of the “diagnostic phase,” but in a case of chronic radiculopathy, as in this patient, the diagnosis has been made. Therefore, there is no current indication for an ESI, according to the criteria of the ODG. The patient’s symptoms have been present for too long and there has not been sustained success documented with ESIs in the past. There are no objective findings of radiculopathy with a normal motor and sensory examination. Therefore, for these reasons, the requested bilateral transforaminal ESI with epidurography at L4-L5 and L5-S1 is neither medically reasonable nor appropriate nor is it in accordance with the ODG.

**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)