



DATE OF REVIEW: 8/10/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical appropriateness of the previously denied request for left-sided L4-L5 and L5-S1 transforaminal epidural steroid injections with fluoroscopy.

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

Texas Licensed Pain Management M.D.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

The previously denied request for left L4-L5 and L5-S1 transforaminal epidural steroid injections.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Fax Cover Sheet dated 8/2/07.
- Notice to CompPartners, INC. of Case Assignment dated 8/2/07.
- Request Letter dated 8/2/07.
- Confirmation of Receipt of Request for Review by an Independent Review Organization Review Organization (IRO) dated 7/27/07.
- Request Form Request for a Review by an Independent Review Organization dated 7/26/07.
- Determination Notification Letter dated 7/5/07, 6/12/07.
- Authorization Request dated 6/27/07.
- Evaluation Report dated 6/26/07, 5/29/07, 4/30/07, 4/19/07, 4/2/07, 3/12/07, 2/21/07, 1/15/07, 11/2/06, 10/12/06, 10/5/06, 7/11/06, 5/30/06, 5/2/06, 4/4/06, 2/23/06, 1/12/06.
- MRI Lumbar Spine dated 10/26/07.

PATIENT CLINICAL HISTORY [SUMMARY]:

Age:

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Lifting injury

Diagnosis: Lumbar disc protrusion; radicular left leg pain.

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

The patient is a male who sustained a work-related lifting injury on xx/xx/xx involving the lumbar spine. Following the injury, the patient complained of low back pain with radiation to the left lower extremity. From the submitted follow-up note of 1/12/06, a lumbar MRI reportedly performed on 7/11/05 revealed a left foraminal disc protrusion at the L4-L5 level. Interestingly, a lumbar MRI report performed on 10/26/06 revealed at the L4-L5 level no disc bulge or herniation, and at L5-S1 level a mild disc bulge with superimposed mild left subarticular foraminal herniation (protrusion), herniation and effacement on L3 and L5 nerve root. The patient was admitted and was treated with conservative treatment under the care and supervision of, M.D. The patient was seen and then transferred in October 2006 to, M.D. Medication management consisted of Lyrica, Pamelor, and Vicodin. Medication management and physical therapy continued through 2006. According to the follow-up note dated 3/12/07, the patient underwent bilateral L5 epidural steroid injections with reported relief up to 4 days of approximately 70 to 80%. However, there was no documentation of increase in the functional activity and/or decrease in medication intake, which would signify clinical benefit. Furthermore, it is the opinion of this reviewer that relief for 4 days was probably a steroid placebo effect. The patient continued on medication profile consisting of Lyrica, Pamelor, and Vicodin. By April 2007, the patient was given a prescription for long-acting opioid (Opana 10 mg one q.12h.) with no instructions to decrease the use of Norco for breakthrough pain. In the follow-up note dated 4/19/07 by Dr., M.D., he stated that the patient has fairly exhausted multiple medications and lumbar epidurals with no significant relief symptomatology. He continued to recommend subsequent interventions in the form of a L5-S1 fusion. There was no documentation submitted clarifying whether or not this request had been certified. In May 2007, the patient was under the care of, M.D., who opined that the patient underwent "right/left" epidural steroid injections as opposed to transforaminal epidural steroid injections. From the last submitted note of this review, dated 6/26/07, it was indicated that the patient continued to have low back and left lower extremity pain. Medication management consisted of Opana ER 10 mg one p.o. b.i.d. and Norco 10/325 mg p.o. q.3-5h., as well continuation of the rest of the medications, which this reviewer interpreted as Lyrica and Pamelor. After the review of the information provided, the decision of denial regarding left L4-L5 and L5-S1 transforaminal epidural steroid injections is upheld. The Official Disability Guidelines indicate, "The importance of epidural steroid injections is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs and avoiding surgery, but this treatment alone offers no significant long-term functional benefits." Furthermore, "There should be documentation of at least 50 to 70% relief of pain from baseline and evidence of improved functional "for at least 6 to 8 weeks after delivery." This clearly has not been the case with this patient. There has been no documentation that the previous lumbar epidural steroid injections have provided substantial and sustained decrease in pain, increase in function, and decrease in medication intake.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE, CHAPTER 12, PAGE 300.

- 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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES, LUMBAR SPINE-EPIDUARL STEROID INJECTIONS.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHRIOPRACTIC QUALITY ASSURANCE AND 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).

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee’s employer, the injured employee’s insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.
