

P&S Network, Inc.

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DATE OF REVIEW: August 23, 2007

IRO CASE #:

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

This case was reviewed by a pain management physician. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Epidural steroid injection

REVIEW OUTCOME

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

Upheld (Agree)

REVIEW OF RECORDS

- o Submitted medical records were reviewed in their entirety.
- o July 2, 2007 utilization review report from M.D.
- o July 11, 2007 utilization review report from M.D.
- o July 5, 2007 pre-authorization request for a lumbar epidural steroid injection from Imaging
- o June 21, 2007 lumbar epidural steroid injection number one report by M.D.
- o March 8, 2007 lumbar MRI report from Center
- o May 3, 2007 initial evaluation report from Orthopedics
- o May 11, 2007 utilization review report by M.D.
- o May 16, 2007 pre-authorization request for a lumbar epidural steroid injection from Imaging

CLINICAL HISTORY SUMMARY

According to the medical records, the patient sustained an industrial injury on xx/xx/xx involving the lumbar spine. A lumbar spine MRI was performed on March 8, 2007 with an impression of moderately severe degenerative spondylosis at L5-S1, moderate to severe neural foraminal narrowing, facet arthropathy, and evidence of an accompanying disc bulge with right paracentral annular tear at L5-S1, multilevel lumbar spondylosis with disc bulges, a broad central 3 mm protrusion at L4-5, and multilevel mild neural foraminal narrowing.

A May 3, 2007 report lists physical examination findings of 5/5 lower extremity strength, sensation intact to light touch, symmetric deep tendon reflexes, and negative straight leg raise bilaterally. Lumbar epidural steroid injections were recommended. On May 11, 2007, lumbar epidural steroid injections were non-certified in utilization review. The reviewer cited the fact that the patient was totally neurologically intact and has imaging that denotes diffuse lumbar spondylosis and disc desiccation. The reviewer noted that an electrodiagnostic study had been performed, but the doctor did not have the report.

The patient was administered a lumbar epidural steroid injection on June 21, 2007. A July 2, 2007 utilization review letter for a second lumbar epidural steroid injection rendered a non-certification for the following reasons. Prior to the procedure, the patient was at an 8/10 pain level and then reported a 5/10 pain level following the injection. The patient had undergone a course of epidural steroid injections in 1996. The reviewer stated that the patient failed to achieve 50% relief and it appeared that the patient had MRI evidence of foraminal stenosis. The physician advisor stated that it is unclear if this is from the disc or bony in

origin, however, in the absence of information, the injection was not indicated.

A reconsideration letter was submitted. The letter states that the referring doctor indicated an impression on May 16, 2007 of lumbar spondylosis most evident at L5-S1, bilateral neural foraminal stenosis at L5-S1, neurogenic claudication-like symptoms, lumbar bulging discs at L2 through S1, low back pain, and lumbar radiculopathy bilaterally. The physician stated that if the lumbar epidural steroid injections were unsuccessful in treating the patient's symptoms, discussion would begin of the possibility of an L5-S1 lumbar fusion. The letter states that any reviewing physician must note that it is perhaps better and perhaps more economical in the short, medium, and long-term for the patient undertake lumbar epidural steroid injections and to become a candidate for surgery due to the delay and inappropriate utilization of resources. The letter notes that a pain level reduction from 8 to 5 is substantial and the consequences of the denial is progression to surgery of the lumbar spine.

The utilization review letter, dated July 11, 2007, also renders a non-certification. The conclusion states that the patient has multiple levels of lumbar spondylosis and neural foraminal narrowing, including the L5-S1 level. The patient has a documentation of some neurogenic claudication as well as spinal stenosis by history and a non-approval was recommended.

ANALYSIS AND EXPLANATION OF DECISION

As noted in the references, the Official Disability Guidelines state that to be considered successful after the initial use of a block, there should be documentation of at least 50-70% relief of pain from baseline and evidence of improved function for at least six to eight weeks after delivery. The records reflect that the patient reported that the pain decreased from 8/10 to a level of 5/10 on a date that was described as "a few days later" following the June 21, 2007 first epidural steroid injection. This does not constitute the 50 to 70% reduction in pain for a minimum of six weeks following the first injection recommended by the Official Disability Guidelines. Thus, a repeat injection is not indicated. My determination is to uphold the previous decisions to non-certify the request for a repeat lumbar epidural steroid injection.

The IRO's decision is consistent with the following guidelines:

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

According to the Official Disability Guidelines for Treatment in Worker's Compensation (2007), at the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections. To be considered successful after this initial use of a block/blocks there should be documentation of at least 50-70% relief of pain from baseline and evidence of improved function for at least six to eight weeks after delivery.