



Lumetra

Brighter insights. Better healthcare.

One Sansome Street, Suite 600
San Francisco, CA 94104-4448

415.677.2000 Phone
415.677.2195 Fax
www.lumetra.com

Notice of Independent Review Decision

DATE OF REVIEW: 12-03-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Transforaminal Epidural Steroid Injection (ESI) at Right L5-S1

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

Certified by The American Board of Orthopedic 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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS, CPT, NDC Codes	Service Units	Upheld/Overturn
		Prospective	724.2 729.5	64483		Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Pre-authorization Review Summary (File Copy)
Pre-authorization Physician Review Form 11-07-07
Pre-authorization Request Form 11-05-07

Progress Notes 09-27-07 & 10-29-07

MRI Lumbar Spine 07-17-07

Official Disability Guideline: Low Back; Treatment Guidelines - ESI

PATIENT CLINICAL HISTORY:

The medical records presented for review begin with a preauthorization physician review form seeking a lumbar transforaminal ESI at the right L5-S1. There was no MRI submitted to support the request, and this was not certified. A physician progress note indicated that this was a chronic pain situation, persistent low back pain with radicular symptoms. An MRI from July 17, 2007, was noted indicating a disc lesion at L5-S1. The physical examination date October 29, 2007, noted tenderness to palpation and no objective signs of a verifiable radiculopathy.

The MRI report noted disc desiccation at the L5-S1 level. Osteophytes were also noted at that level. A posterior central disc lesion was reported, however, no stenosis or nerve root encroachment was associated with this disc. A slight right foraminal stenosis was noted "primarily related to the vertebral body margin osteophyte formation."

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

In the opinion of the Reviewer, the request for a lumbar transforaminal ESI at L5-S1 is not medically necessary. This is a xx-year-old lady who fell and landed on her hip. There are reported low back complaints, but there is a minimum of acute objective pathology noted. There is no verifiable evidence of radiculopathy including positive EMG and muscle atrophy consistent with ODG criteria.

The Reviewer noted that there are multiple degenerative changes (desiccation and osteophytes) that could explain what the pain generator is, and the requested procedure would not address or suppress the pathology. Given the long term, "chronic" pain and degenerative changes, this procedure would not be supported by the notation of the ODG. As reported in the ODG, such an injection is "recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatome; distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts."

Also, as noted in the Pain section of the ODG, "Radiculopathy symptoms are generally due to herniated nucleus pulposus (HNP) or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition."

The Reviewer noted the findings of the MRI that there was no HNP and findings of a minor, non-acute disc bulge of 2 mm.

Lastly, as noted in the ODG, “The American Academy of Neurology recently concluded that epidural steroid injections do not provide long-term relief beyond 3 months. (Armon, 2007)”

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)**