

# Clear Resolutions Inc.

An Independent Review Organization  
7301 Ranch Rd 620 N, Suite 155-199  
Austin, TX 78726  
Fax: 512-519-7316

**DATE OF REVIEW: OCTOBER 13, 2007**

**IRO CASE #:**

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

Outpatient Right L5 & S1 TFLESI Epidural Steroid Injections

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

## **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 or not medical necessity exists for each of the health care services in dispute.

A repeat right L5, S1 transforaminal epidural steroid injection in the diagnostic phase is indicated in this patient's situation. Per the Official Disability Guidelines, a second block is not recommended if there is inadequate response to the first block. In this situation, adequate response was received (60% reduction of pain) for approximately one month at the time of my review.

<i>Injury Date</i>	<i>Claim Number</i>	<i>Review Type</i>	<i>Begin Date</i>	<i>End Date</i>	<i>ICD-9/DSMV</i>	<i>HCPCS/NDC</i>	<i>Upheld Overturn</i>

		<i>Prospective</i>	<i>09/4/2007</i>	<i>10/4/2007</i>	<i>847.2</i>	<i>62289</i>	<i>Overturn</i>
--	--	--------------------	------------------	------------------	--------------	--------------	-----------------

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**Adverse Determination Letters, 8/15/07, 9/4/07**  
**Official Disability Guidelines and Treatment Guidelines**  
**Dr. Letter of Reconsideration, 9/4/07**  
**Dr. Follow-up visit, 9/10/07**  
**Dr. Pain Management Follow-up visit, 8/8/07**  
**Dr. Pain Management Procedure note, 8/1/07**  
**Dr. Pain Management Consultation, 7/18/07**  
**Dr. Letter of reconsideration, 8/25/07**  
**Dr. Letter to Dr. 8/25/07**  
**MRI Findings, 5/18/07**  
**Pre-certification Request, 8/13/07**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient was injured when she was lifting heavy equipment (weighing approximately 100 pounds). During the lifting of this heavy equipment, there was an onset of low back pain that radiated to the right lower extremity. She received a right L5, S1 transforaminal epidural steroid injection on 08/01/2007. On review of the most recent note written on 09/04/2007, it was noted that the patient was still receiving 60% pain relief and able to decrease the intake of opioid medications. It is noted that she has received conservative treatment in the past including physical therapy and medication management. An MRI of the lumbar spine shows an asymmetric disc protrusion at L5-S1 which is encroaching at the neural foraminal level crowding the exiting L5 nerve root. The request is for a repeat right L5, S1 transforaminal epidural steroid injection based on the fact that the patient has received 60% pain relief for approximately one month during the diagnostic phase.

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

Per Official Disability Guidelines, “a maximum of two injections should be performed at the time of the initial use of epidural steroid injections. A second block is not recommended if there is inadequate response to the first block.” The Official Disability Guidelines go on to state, “There should be an interval of at least one to two weeks between injections.” Given that this patient continues to receive 60% pain relief as of the last note written on 09/04/2007, I feel that a repeat right L5, S1 transforaminal epidural steroid injection is indicated.

**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)