

# US Decisions, Inc.

*An Independent Review Organization*

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 04/08/2008

**IRO CASE #:**

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

Lumbar Epidural Steroid Injection w/ Fluoroscopy

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

Board Certified Neurosurgeon with additional training in Pediatric Neurosurgery

### **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)

Upon independent review the reviewer finds that the requested Lumbar Epidural Steroid Injection with Fluoroscopy is not medically necessary.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters 2/14/08, 3/5/08

ODG Guidelines and Treatment Guidelines

MD Notes 2/25/08, 2/7/08, 12/3/07, 10/22/07, 10/1/07, 9/10/07

Operative Report of epidural steroid injection 12/19/07

Diagnostic Imaging 9/26/07 Lumbar Radiculopathy- Myelogram w/ CT Lumbar

MRI of the lumbar spine report 08/16/2007

Progress Report Dr. 8/24/07

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a xx year-old male who has a date of injury xx/xx/xx when he fell off a trailer. He complains of low back and bilateral hip and leg pain, right greater than left. Neurological examination reveals a positive straight-leg raising bilaterally. He had an epidural steroid injection 12/19/2007, which had "excellent results". He is now having a return of his symptoms. A CT myelogram 09/2007 revealed small disc bulges at multiple levels with lateral recess narrowing at L4-L5. At L5-S1 there is mild left foraminal encroachment. An MRI of the lumbar spine 0816/2007 revealed minimal disc bulging into the foramina on the right and left at L4-L5. The provider is requesting a repeat epidural steroid injection.

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

The ESI is not medically necessary. According to ODG, there needs to be objective evidence of a radiculopathy. A positive straight-leg raising bilaterally does not constitute objective evidence of a radiculopathy. In addition, the imaging findings are quite mild and would marginally cause any radiculopathy. Lastly, as pointed out by other reviewers, a prior response to ESI needs to be quantified, both in terms of degree and duration, before another ESI is medically necessary.

### **References/Guidelines**

Occupational and Disability Guidelines

"Low Back" chapter

#### **Criteria for the use of Epidural steroid injections:**

*Note: The purpose of ESI 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 benefit.*

- (1) Radiculopathy must be documented. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. ([Andersson, 2000](#))
- (2) In the therapeutic phase (the phase after the initial block/blocks were given and found to produce pain relief), repeat blocks should only be offered if there is at least 50-70% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. ([CMS, 2004](#)) ([Boswell, 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)