

## Notice of Independent Review Decision

### **DATE OF REVIEW:**

08/22/2008

### **IRO CASE #:**

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

Please review the item in dispute: right transforaminal lumbar steroid injection (ESI) L5-S1, 64483, 73542, 77003, J1040, J3010, J2250, J2001, J7720, 09966, 99144, and 49445.

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

Board Certified Physical Medicine and Rehabilitation Physician

### **REVIEW OUTCOME**

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

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.

The requested right transforaminal lumbar ESI at L5-S1 and 64483, 73542, 77003, J1040, J3010, J2250, J2001, J7720, 09966, 99144, and 49445 is not medically necessary.

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

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 08/05/08 MCMC Referral
- Notice of Assignment of Independent Review Organization,
- 08/05/08 Notice To MCMC, LLC Of Case Assignment,
- 08/04/08 Confirmation Of Receipt Of A Request For A Review, DWCO
- 07/30/08 letter from M.D.
- 07/28/08 Request For A Review By An Independent Review Organization
- 07/15/08 Subsequent Visit note, Workmen's Compensation
- 07/03/08 letter from CI Rep,
- 07/02/08, 06/27/08 reports from R.N.
- 06/18/08 letter from CI Rep,
- 06/18/08, 06/16/08 reports
- 06/27/08, 06/12/08 Pre-Authorization Form – Facsimile Cover Sheet,
- 06/11/08 lab report, Diagnostics
- 07/11/08, 06/09/08, 04/07/08 Follow-Up Visit notes,
- 06/09/08, 04/07/08 Follow-Up Visit, M.D., Pain Management

- 03/05/08, 02/20/08 Operative Reports, M.D., Pain Management
- 02/25/08 EMG/nerve conduction study, M.D., Center
- 02/19/08 Designated Doctor Evaluation (Report of Medical Evaluation, M.D., Health Center
- 02/07/08 Comprehensive Initial Evaluation, M.D.
- 01/??/08 Electro-Diagnostic Interpretation report, M.D.,
- 10/24/07 Page 2 of report from M.D.
- 10/19/07 MRI lumbosacral spine, Radiology
- 10/02/07 lumbar spine radiographs, MRI Center
- 10/02/07 left rib radiographs, MRI Center
- 10/02/07 CT brain, MRI Center
- 10/02/07 MRI left shoulder, MRI Center
- Undated information on Definition and Causes of focal neurological deficit
- Note: Carrier did not supply ODG Guidelines.

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

The injured individual is a male who has history of chronic low back pain with a date of injury of xx/xx/xx. According to a clinic note by Dr. on 02/7/2008, there was mention of the back pain occurring along with some lower extremity numbness symptoms. Also per 02/07/2008 note, there was some tenderness in the lumbosacral interspinal and paraspinal regions as well as L4-5 and L5-S1 facet levels and sciatic notch, sitting and supine straight leg raise (SLR) was positive bilaterally, sciatic tension was positive bilaterally, prone hip extension and prone knee flexion was positive bilaterally, Patrick's/Fabere's tests were positive bilaterally, and otherwise physical exam was unremarkable. A lumbar MRI study on 10/19/2007 revealed disc bulging/protrusion/desiccation at the L3-4 and L5-S1 levels with a small subligamentous disc herniated fragment at both the L3-4 and L5-S1 levels and facet arthropathy in the lowest three levels per radiology report. A lower extremity electrodiagnostic study on 02/25/2008 revealed a minimal right L5-S1 radiculopathy per report. Lumbar ESI treatment at L5-S1 was done by Dr. on 02/20/2008 and 03/05/2008 according to procedure notes. According to a clinic follow-up note by Dr. on 04/07/2008, there was mention that only 40-50% pain relief was achieved for two weeks after the 03/05/2008 injection.

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

There was no indication from the available documentation/information of any significant long term pain relief or improvement in function being achieved from the initial first two ESI treatments. There was indication that an objective radicular component was occurring based on the physical exam findings and workup done, but since no long lasting pain relief and not much improvement was achieved from the first two ESI's, additional ESI treatment is not appropriate or indicated and this follows the parameters within the Official Disability Guidelines. As a result, the requested right transforaminal lumbar ESI at L5-S1 and 64483, 73542, 77003, J1040, J3010, J2250, J2001, J7720, 09966, 99144, and 49445 is not medically necessary.

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



## **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

ODG guidelines regarding ESI treatment for the low back, “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. If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be required. This is generally referred to as the therapeutic phase. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. Current research does not support a routine use of a series-of-three injections in either the diagnostic or therapeutic phase.”