Independent Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

Amended 8/4/08
8/4/08

DATE OF REVIEW: 08/03/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Lumbar ESI

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 7/25/08, 4/4/08, 07/17/08
Medical Records from Dr.: 1/28/08, 03/25/2008 05/08/2008, 06/10/2008, 07/08/2008
MRI of the lumbar spine report 1/16/08

PATIENT CLINICAL HISTORY [SUMMARY]:
This is a female with a date of injury xx/xx/xx while moving a patient . She complains of low back pain, radiating down her right leg to her calf. A more recent note states the pain

is on the left, and occasionally on the right. She has had physical therapy, chiropractic therapy, and work conditioning. She did not tolerate work conditioning. Neurological examination reveals absent knee jerks bilaterally. Both Achille's jerks are present. There is some decreased sensation in the S1 and L5 distribution on the right. There is weakness of the right hamstring muscles. An MRI of the lumbar spine 01/16/2008 revealed an L5-S1 left posterolateral annular tear with a small left disc herniation. Also, there is minimal disc dessication. At L3-L4 there is minimal disc dessication with slight narrowing and minimal disc bulging; there is no significant canal stenosis. Electrodiagnostic testing 01/26/2008 was normal. The provider is requesting a lumbar ESI.

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 the ODG, there must be objective evidence of a radiculopathy in order for an ESI to be medically necessary. In this case, there is no objective evidence of a radiculopathy. There is some weakness of the hamstring muscles on the right, and there is a small disc herniation at L5-S1 to the left. Therefore, based on the submitted documentation, the lumbar ESI is not medically necessary.

References/Guidelines

2008 *Official Disability Guidelines,* 13th edition
"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) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.

(4) *Diagnostic Phase:* 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 one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). 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.
(5) No more than two nerve root levels should be injected using transforaminal blocks.
(6) No more than one interlaminar level should be injected at one session.
(7) *Therapeutic phase:* 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." Indications for repeat blocks include acute exacerbation of pain, or new onset of symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)
(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.
(9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.
(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks as this may lead to improper diagnosis or unnecessary treatment.
(11) Cervical and lumbar epidural steroid injection should not be performed on the same day.

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)**