

Applied Assessments LLC

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: 08/03/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Lumbar ESI #2 under anesthesia with fluoroscopy guidance

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Denial Letters 5/12/08 and 6/4/08
Records from Dr. 3/5/08 thru 6/18/08
MRI 9/28/06

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured on the job on xx/xx/xx while lifting a "20-foot bin." On 03/05/08, the patient was noted to be complaining of pain in the lower back and left knee. There is an MRI of the lumbar spine that shows disc bulges at L4-5 and L5-S1. The patient underwent an L4-5 interlaminar epidural steroid injection on 04/16/08. It is noted on an office visit note dated 04/30/08 that the patient received 10% improvement in pain and function status post the epidural steroid injection. On the office visit note dated 05/28/08, the patient reported a 20% decrease in pain from the epidural. On an office visit note dated 06/11/08, there is no description of the patient's pain complaints. There is only a chief complaint

provided of low back pain and left knee pain but no specific description of the patient's pain or any radicular symptoms. There is also no discussion of the previous results of the last epidural steroid injection which were reported in the office visit notes described above. It is also noted on the physical exam that there is no musculoskeletal exam performed at all and the neurological exam does not describe anything that would relate to a radicular symptom. It is interesting, however, that there is a letter of appeal provided from 06/18/08 which states that the patient received greater than 70% pain relief from the first injection. This was never described in any of the previous office visit notes. In addition, there is no mention in this letter as to whether or not there was an increase in function or reduction in medication usage. There is also no mention of the patient being involved in an active treatment program of either physical therapy or a home exercise program.

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

Per the *Official Disability Guidelines*, a diagnostic epidural steroid injection is "not recommended if there is inadequate response to the first block (less than 30%)." Given that this patient received 10-20% relief, this would not be considered an adequate response. Even if this was a request for a therapeutic epidural steroid injection, it would not be indicated because pain relief of 50-70% is required for at least 6-8 weeks. That is not the case with this patient. Two months after the epidural steroid injection the patient reported 70% relief as indicated by the letter dated 06/18/08. It did not discuss any increased function or reduction in medication usage from the ESI. Therefore, given that this does not follow the *Official Disability Guidelines*, it is not an appropriate request.

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 KNOWLEDGBASE
- 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)**