SENT VIA EMAIL OR FAX ON
Dec/22/2008

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/20/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
#2 Epidural Steriod Injection under Fluoroscopic Control with Epidurogram of the Lumbar Region

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

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

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Office note, Dr. , 08/12/08
DDE, Dr. , 09/25/08
ESI, 10/10/08
Epidural Steroid Injection Follow up Questionnaire
Note, , 10/20/08, 11/10/08
Reconsideration request, Dr. , 10/28/08
Medical conference, 11/06/08
Note, Dr. , 11/14/08

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a xx year old male injured on xx/xx/xx. The mechanism of injury was not provided. On 08/12/08 Dr. documented that the claimant had an L4-5 PLIF in 03/05 with pseudoarthrosis. A CT myelogram in 02/07 reportedly showed decreased filling at L3-4 bilaterally and some lucency around the L5 pedicle screw. The CT showed an L3-4 protrusion into the foramina and an L5-S1 protrusion into the foramina causing stenosis. Also noted was lucency of the L4-5 endplates. Two epidural steroid injections in the past had

given him 50 percent relief of back pain and total relief of leg pain. On examination there was iliopsoas weakness and dorsiflexion weakness on the left with hypoesthesia of the left foot and an absent Achilles. The impression was L4 and 5 radiculopathy, possible pseudoarthrosis, status post PLIF, L3-4 stenosis and impingement of L5 nerve root sleeve and L5-S1 foramen.

On 10/10/08 the claimant had an epidural steroid injection. A questionnaire was reportedly filled out 4 days after the injection and the claimant reported decreased frequency, duration and intensity of pain. Pain was 5/10 prior to the injection and 1/10 after. Mobility was also reported to be increased.

An additional injection was denied based on ODG recommendations.

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

The requested second epidural steroid injection meets appropriate percentage relief criteria by ODG guidelines but does not meet appropriate duration of therapeutic efficacy guidelines.

Specifically, ODG requires 50 to 70 percent relief from an injection for six to eight weeks before a second injection is recommended. The duration of clinical relief is unclear, according to the records reviewed. More documentation of the duration of relief during the therapeutic phase is required by ODG guidelines before medical necessity can be determined for repeat injections. Therefore the medical necessity of #2 epidural steroid injection under fluoroscopic control with epidurogram of the lumbar region cannot be recommended as medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2008, Low Back- Epidural steroid injections (ESIs), therapeuti

Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts.

Indications for repeating ESIs in patients with chronic pain at a level previously injected (> 24 months) include a symptom-free interval or indication of a new clinical presentation at the level.

Criteria for the use of Epidural steroid injections

Note: The purpose of ESI is to reduce pain and inflammation, 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.

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

[ ] ACOEM-AMERICA 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)