

Notice of Independent Review Decision

DATE OF REVIEW: 03-19-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Epidural steroid injection (ESI) - lumbar with fluoroscopy

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

Certification by the American Board of Anesthesiology
Anesthesiology – General
Pain Medicine

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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Service Unit	Upheld/ Overturned
		Prospective	722.10	62311	1	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Denial Notice dated, 02-14-08 and 02-14-08
Case Report dated, 02-14-08 and 02-28-08

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Authorization Request dated, 02-25-08
Progress notes dated, 02-07-08, and 02-21-08
Physician prescription lumbar spine epidural block dated, 02-07-08 and 02-21-08
MRI report dated, 08-24-07
Physical Therapy notes dated, 01-18-08 (initial), 01-21-08, 01-23-08, 01-25-08,
01-28-08, 01-30-08, 02-01-08, 02-04-08, 02-06-08, 02-8-08, and 02-11-08
Texas Workers' Compensation Work Status Report dated, 02-21-08
Official Disability Guidelines (ODG) Criteria for use of ESI

PATIENT CLINICAL HISTORY:

According to the medical data provided, the patient is complaining of chronic low back pain with lower extremity referred pain that resulted from a work related injury in xx/xx. A Lumbar Spine MRI evaluation in August 2007 revealed moderate degenerative disc disease at L5-S1 with a mild annular bulge and mild bilateral neuroforaminal narrowing. An initial ESI with fluoroscopy was performed on November 29, 2007, with no significant benefit according to medical documentation. A physical therapy progress note indicated that the procedure "helped for only 2 days", and there is no further documentation presented that indicates the percent improvement or duration of benefit. Nor is there documentation present that indicates whether the "2 days" of benefit was with the patient's axial low back symptoms or lower extremity symptoms.

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

In the opinion of the Reviewer, the second ESI with fluoroscopy is not medically necessary and the claimant does not meet the criteria for a second injection as recommended by ODG. The ODG indicated that any repeat procedures depend on the quality of benefit from the previous procedure. Per the ODG, criteria for ESI include the following:

Radiculopathy must be documented: The review of the provided medical data indicates no physical examination findings of radiculopathy or nerve root irritation. A progress note from February 4, 2008 describes pain radiating to bilateral lower extremities while a progress note from February 21, 2008 indicated pain only radiating to the left lower extremity, but none of these progress notes include physical examination findings of nerve root irritation.

Injections should be performed using fluoroscopy and injection of contrast:

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No documentation of the procedure performed on 11/29/07 was provided. The approach to the epidural space, either interlaminar or transforaminal is unknown.

At the time of initial use of an ESI, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. A second block is also not indicated if the first block is accurately placed. To be considered successful after this initial use of block/blocks, there should be documentation of a least 50-70% relief of pain from baseline and evidence of improved function for at least six to eight weeks after delivery: It is noted the initial ESI "helped for only 2 days".

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

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- 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)**