

## Notice of Independent Review Decision

DATE OF REVIEW: 09/29/08

IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar epidural steroid injection

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

### 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)

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.

It is determined that the lumbar epidural steroid injection is not medically necessary to treat this patient's condition.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Notice to Utilization Review Agent of assignment of IRO – 09/16/08
- Request for preauthorization/utilization review from Dr. – 07/31/08
- Office visit notes from Dr. – 11/15/05 to 07/01/08
- Discharge Summary from Medical Center by Dr. – 03/31/08, 04/01/08, 04/28/08
- Operative Report – 03/28/08, 04/18/08, 04/25/08
- Consultation by Dr. – 03/30/08, 04/26/08

- Letter to TMF – 09/22/08
- Letter of determination – 10/30/03, 11/06/03, 11/18/08, 04/10/04, 05/04/05, 07/20/05, 02/15/08, 08/29/08, 07/31/08, 08/08/08, 08/11/08
- Designated Doctor Evaluation by Dr. – 02/06/06
- Information for requesting a review by an IRO – 09/16/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when he fell into a machine resulting in injury to both shoulders, both knees, his neck, his lower back and his left hip. The patient has a past history of lumbar spine surgery in 1996 resulting in L4-L5 laminectomy and fusion. He is suffering lumbar spine pain since his most recent injury. The patient has been treated with repeated lumbar epidural steroid injections. His first series of 3 injections was in December of 2003, a second series of 3 injections in August of 2004, a third series of 2 injections in May of 05 and July of 05 and a fourth single injection in April of 08.

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

See ODG, 2008, passages concerning the treatment of lumbar pain utilizing the epidural steroid injection (ESI) technique. The passages are from the chronic pain chapter (updated 09/24/08) and the low back chapter (updated 09/23/08). Under the circumstances evidenced by this patient's treatment, beneficial results have not been of sufficient duration to justify further repeated use. The ESI were initially recommended as treatment for acute low back pain with radiculopathy. There is no documentation of radiculopathy. Under circumstances of chronic low back pain, beneficial results should reach 24 months or more. At no time have beneficial results achieved even 12 months duration. Therefore, it is determined that the ESI's are not medically indicated based on criteria published in the ODG, 2008.

**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)