



Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 8/27/2009

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for a lumbar epidural steroid injection (ESI).

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

Texas licensed Anesthesiology/Pain Management Physician.

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.

The previously denied request for a lumbar epidural steroid injection (ESI).

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- IRO Request form dated 8/13/09
- Letter dated 8/18/09
- Low Back-Lumbar & Thoracic Treatment Planning dated 8/18/09
- Adverse Determination After Reconsideration Note dated 8/4/09
- Fax Cover Sheet dated 7/27/09
- Adverse Determination Notice dated 7/16/09
- Notes dated 7/9/09
- Peer Review dated 6/12/09
- Notes dated 1/8/09
- Physical Examination dated 10/17/08
- Report of Medical Evaluation dated 10/17/08
- Required Medical Examination dated 6/09/08
- Report of Medical Evaluation dated 6/9/08
- Final Report dated 3/28/08

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Slip and fall

Diagnosis: Chronic low back pain

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

This xx-year-old male had a history of low back pain since xx/xx/xx, when he slipped and fell. The patient was diagnosed with chronic low back pain. According to the medical note, the low back pain radiated into the left lower extremity. The pain is rated 8 on a 0-10 pain scale. There was associated numbness of the left leg. On physical examination, there was decreased range of motion in the lumbar leg test with no tenderness. Sensory and motor examination was normal. Straight leg test was positive on the right at 45 degrees and on the left at 30 degrees. There was weakness in the L4-L5 and L5-S1 distribution. An MRI showed a disc bulge at L4-L5 and L5-S1, with canal stenosis. The patient has had multimodality conservative treatment including ESI on 01/2009, which gave the patient pain relief for several months. The request is now for a lumbar epidural steroid injection, which is really a repeat injection. The Official Disability Guidelines

state, "(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. (8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response." This patient meets the above criteria for a repeat ESI and the request should be approved.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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. Official Disability Guidelines (ODG), Treatment Index, 7th Edition (web), 2009, Low back—Epidural steroid injections (ESIs), Therapeutic.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).