

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 21, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Lumbar ESI with Fluoroscopy

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of 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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
unk	Lumbar ESI		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-16 pages

Respondent records- a total of 151 pages of records received by FOL to include but not limited to: FOL letter 12.4.09; ODG guidelines low back-Lumbar and Thoracic; Dr. records 3.4.09-11.4.09; Specialty Hospital records 3.7.09-10.13.09; HDI letter 11.3.09; MRI L spine 5.20.09; various DWC

73; Spine and Rehab Specialists record 6.22.09; report, Dr. 2.19.09, 5.15.09; DWC 45; report, Dr. 4.28.09

Respondent records- a total of 66 pages of records received by URA to include but not limited to: TDI letter 12.1.09; records, Dr. 3.4.09-11.4.09; MRI L spine 5.20.09; Specialty Hospital records 1.13.09-10.13.09; MCMC report 4.27.09

Requestor records- a total of 42 pages of records received to include but not limited to: PHMO request for records; TDI 12.1.09; records, Dr. 3.4.09-11.4.09; MRI L spine 5.20.09; Specialty Hospital records 1.13.09-10.13.09

PATIENT CLINICAL HISTORY [SUMMARY]:

The records presented for review begin with an IRO determination that the date of injury was xx/xx. Multiple level facet degenerative changes were noted. There were three epidural steroid injections completed with a "varied response." At most the recent injection provided only 20% relief. There was a vertebroplasty completed and no radicular symptoms. The denial for the request for additional epidural steroid injections was upheld.

The progress notes of Dr. noted significant pain complaints and this was treated with narcotic medications. In April 2009, Dr. also noted a chronic intractable pain syndrome. Dr. noted the parameters for epidural steroid injections as per the OPDG, however, he felt that treatment outside these guidelines was warranted in this case. Dr. felt that the non-certification of care outside the ODG was inappropriate. A surgical consultation was requested. In his evaluation, Dr. noted that the symptoms associated with the compensable injury. Approximately six weeks of no symptoms, the injured employee was changing a tire and re-injured himself causing the current symptoms. A repeat MRI was sought.

Dr. continued to prescribe narcotic medications every four hours around the clock. In June repeat epidural steroid injections are done. It is noted that there was a 75% improvement in the pain complaints. A second injection is sought.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

As noted in the Division mandated Official Disability Guidelines (Pain chapter updated December 8, 2009) a series of three is not supported.

Further, as noted in the xx/xxMRI, the compression fracture is well healed without complications. There are no disc lesions and the pain complaints do not have any clinical foundation. The response has been varied and there is no clear clinical indication presented why repeat injections are warranted or are a function of the compensable injury alone.

Lastly, the criteria for epidural steroid injections are noted as 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 by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.

2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

3) Injections should be performed using fluoroscopy (live x-ray) for guidance.

4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and [functional improvement](#), including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. ([Manchikanti, 2003](#)) ([CMS, 2004](#)) ([Boswell, 2007](#))

8) Current research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.

9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block.

Due to these criteria not being met or objectified in the progress notes presented for review, the denial is upheld.

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

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

XX 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)