

SENT VIA EMAIL OR FAX ON
Nov/03/2009

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/02/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Transforaminal Epidural Steroid Injection

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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Peer Review 07/23/09, 08/26/09, 09/22/09,.10/08/09

Lumbar MRI 11/03/08

EMG/ NCS 12/15/08

FCE 01/30/09

Dr. OV 07/06/09, 07/23/09, 08/07/09 0827/09, 09/04/09

PATIENT CLINICAL HISTORY SUMMARY

This is a male claimant reportedly developed low back pain on xx/xx/xx after lifting a stocking tile. A 11/03/09 lumbar MRI showed lumbar spondylosis at multiple levels, disc protrusion L3-4 and L4-5, disc protrusion L5- S1 with impingement on the descending right S1 nerve root and bilateral neural foraminal narrowing secondary to disc bulge and facet joint degenerative changes.

An EMG/ NCS of the right lower extremity performed on 12/15/08 revealed a normal right leg with no evidence of radicular injury.

A physician record dated 07/06/09 noted the claimant had cramping lumbar pain since the

xx/xx/xx injury that had improved and become intermittent. The claimant denied any lower extremity radicular symptoms. Lumbar x-rays taken were normal. Conservative care to include home exercise, chiropractic care and continuation of medications was recommended along with epidural steroid injection and selective block discussion.

A 08/07/90 follow up physician record revealed the claimant with discomfort on lumbar range of motion but doing well. A review of the 11/03/09 lumbar MRI revealed a right sided L5- S1 disc herniation compressing the S1 nerve root.

A physician record dated 09/04/09 noted the claimant with constant lumbar pain with no radicular pain other than generalized leg stiffness. An examination revealed guarded lumbar motion and diminished left patellar and Achilles reflexes. The claimant was diagnosed with lumbago, lumbar disc derangement and lumbar herniated disc. Reconsideration for the transforaminal lumbar epidural steroid injection for diagnostic and therapeutic purposes was again requested.

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

The requested epidural steroid injections cannot be justified as medically necessary.

The most recent note of 09/04/09 notes that the claimant "does not have any radicular pain." Neurological exam is noted to be intact with a negative straight leg raise. The claimant does not have focal radiculopathy on exam. The claimant, therefore, does not meet ODG criteria for the requested injections.

Official Disability Guidelines 2009 Low Back Epidural steroid injections (ESIs),

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.

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.

(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” injection 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.
- (10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
- (11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

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
- 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)
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