

C-IRO Inc.

An Independent Review Organization
7301 RANCH RD 620 N, STE 155-199B
Austin, TX 78726
Phone: (512) 772-4390
Fax: (512) 519-7098
Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/02/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Rt Transforaminal ESI L4/L5 L5/S1 64483 64484

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

M.D., 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

ODG Guidelines and Treatment Guidelines

Peer review, Dr. , 8/17/09

Peer review, Dr. , 8/28/09

Lumbar Spine MRI, 2/13/09

Office notes, Dr. , 6/24/09, 08/21/09, 09/09/09

Office notes, 7/22/09, 08/05/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who reported a sudden onset of lower back and leg pain following an injury on xx/xx/xx. Lumbar MRI on 02/13/09 revealed severe degenerative discogenic disease at L5-S1 with a left foraminal disc herniation left sided lateral recess narrowing, and severe compression of the left traversing S1 nerve root with mild compression of the right S1 nerve root. There was disc bulge at L3-4 with mild spinal canal stenosis but no nerve root compromise. Activity modification, physical therapy, and anti inflammatory medication provided no significant relief of back and leg pain. On examination, straight leg raise was positive bilaterally, right greater than left with diminished sensation, and positive Slump's testing at L4 through S1. The claimant underwent a right sided L4-5, L5-S1 epidural steroid injection in July 2009 with eighty percent relief of symptoms. A second injection was requested in conjunction with an aquatic rehab program and an attempt at return to work.

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

There is a positive straight leg raise on examination that improved to merely mildly positive on the right following the initial injection. The claimant had overall 80 percent relief with the initial injection. The claimant therefore appears to have substantial relief after a prior epidural steroid injection. The claimant would meet the recommended guidelines for a 2nd epidural steroid injection. The reviewer finds that medical necessity exists for Rt Transforaminal ESI L4/L5 L5/S1 64483 64484.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates, Low Back, Epidural Steroid Injections

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. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. (Andersson, 2000)
- (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 "series-of-three" injections 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)