

# I-Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Oct/26/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar ESI L4-5

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

MD, Board Certified in Physical Medicine and Rehabilitation  
Board Certified in Pain Management

**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

Adverse Determinations, 7/10/09, 8/10/09

DO, 8/20/09, 7/23/09, 6/25/09, 5/26/09, 4/27/09, 3/26/09,  
2/26/09, 1/26/09, 12/18/08, 11/20/08, 10/21/08, 9/23/08, 8/26/08, 7/24/08,  
6/26/08, 5/30/08, 4/22/08, 3/25/08

Operative Report, 1/16/09, 5/23/08

**PATIENT CLINICAL HISTORY SUMMARY**

This is a woman reportedly injured on xx/xx/xx. There is no description of the injury and reportedly surgery. She has a history of back pain going to the right lower extremity. An MRI report was not provided, but there were comments in the records about bilateral disc herniations at L4/5 and L5/S1. She reportedly has a normal neurological examination except for reduced light touch sensation in her medial thighs. There is a diagnosis of a L4/5 radiculopathy. She had an ESI on 5/23/08 and had relief until she needed a repeat on 1/16/09. She began having symptoms in June 2009 and these persisted according to the August 2009 note.

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

The ODG recommends ESI 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. This patient appears to meet the criteria for the use of Epidural steroid injections, including criteria 7 for a therapeutic injection, and criteria 8 for a repeat injection. The reviewer finds that medical necessity exists for Lumbar ESI L4-5.

Epidural steroid injections (ESIs), therapeutic

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. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition....

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 a "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.

## **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)