Notice of Independent Review Decision

Date of the Notice of Decision: 04/06/10, Revised 04/09/10

DATE OF REVIEW: 04/06/10, REVISED: 04/09/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Transforaminal Epidural Steroid Injection at the Bilateral L4 and L5 Level Between 03/11/10 and 05/10/10

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Board Certified in Anesthesiology with Certificate of Added Qualifications in Pain 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)

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.

Transforaminal Epidural Steroid Injection at the Bilateral L4 and L5 Level Between 03/11/10 and 05/10/10 - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Initial Office Visit, M.D., 02/21/08
- Office Visit, Dr. 02/05/09, 05/22/09, 08/18/09, 09/04/09, 10/20/09, 12/01/09, 02/11/10
- MRI Lumbar Spine, M.D., 05/22/09, 10/20/09
- Initial Consultation, M.D., 06/18/09
- Office Visit, Dr. 02/01/10
- Operative Report, Dr. 06/29/09
- Operative Report, Dr. 08/19/09
- Pre-Authorization Request, Dr. 02/01/10

- Denial Letter, 02/05/10, 02/24/10, 03/15/10
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient had complaints of low back pain and shooting bilateral leg pain. An MRI of the lumbar spine showed mild degeneration of the L4-L5 disc with mild degeneration at the remaining levels. At L4-L5 there was a 3 mm posterior central disc protrusion with moderate bilateral foraminal narrowing and moderate narrowing of the canal due to facet hypertrophy and mildly prominent posterior epidural fat. He underwent bilateral L5 Epidural Steroid Injection (ESI), and at L4. He then underwent a bilateral laminotomy with partial facetectomy, foraminotomy and discectomy at L4-L5. A second lumbar MRI was performed, which basically was unchanged. He underwent a course of physical therapy. He was maintained on Atenolol 50 mg, Aspirin 325 mg, Gemfibrizil, Lisinopril 20 mg, Hydrocodone 10/325 mg and Diclofenac 75 mg.

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

According to ODG criteria, it is medically reasonable and necessary for epidural steroid injections to be performed when there is evidence of radiculopathy by either physical examination or electrodiagnostic studies, which is corroborated by imaging study evidence of disc herniation and neural compression corresponding to the distribution of pain and examination or electrodiagnostic study evidence of radiculopathy. In this case, neither of those criteria has been or is currently being met. The patient does not have physical examination or electrodiagnostic evidence of radiculopathy, and also has no MRI scan evidence of disc herniation producing neural compression. Therefore, by ODG criteria, this patient is not an appropriate candidate for epidural steroid injections. Additionally, the patient had previously undergone this identical procedure on 06/29/09, which provided him with no more than two months of non-specified degree of relief at most. It is never medically reasonable or necessary to repeat any medical procedure which does not provide significant clinical benefit, which is certainly the case with this patient. Finally, Dr. the requesting physician, himself stated in his evaluation on 02/01/10 that “this patient does not meet ODG criteria for repeat injection.”

Therefore, based upon the requesting physician’s own documentation and lack of meeting ODG criteria for epidural steroid injection, there is no medical reason or necessity for the requested bilateral L4 and L5 transforaminal epidural steroid injections. MRI scan does not demonstrate disc herniation or nerve root compression at the L4-L5 or L5-S1 levels nor any evidence of L4 or L5 nerve root compression. The most recent physical examination by Dr. on 02/11/10 also demonstrated no evidence of radiculopathy to justify the request. Therefore, the two previous recommendations for non-authorization of the requested transforaminal epidural steroid injection at the bilateral L4 and L5 levels are upheld. There is no medical reason or necessity for the requested procedure.

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

- ☐ **ACOEM - AMERICAN 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)**