

## Notice of Independent Review Decision

**DATE OF REVIEW:** AUGUST 17, 2010**IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Lumbar ESI Caudal

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

This physician is Board Certified by American Board of Physical Medicine and Rehabilitation with 14 years of experience.

**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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

On January 5, 2010, Mr. was evaluated by, D.O. He stated that is still having pain in his neck, some pain into his hand but his main complaint is neck pain. Dr. recommended a chronic pain management program. X-rays show good position of the plate and screws as well at the lateral mass screws.

On February 1, 2010, an MRI of the lumbar spine was performed. Impression:  
1. Mild disc degeneration and diffuse 6 mm posterior disc protrusion at L4-L5 with bilateral facet and ligamentous hypertrophy and bilateral facet osteoarthritis-with marked canal stenosis and moderate bilateral foraminal stenosis. 2. Mild disc degeneration and diffuse 2 mm posterior disc bulge at L3-4 with mild bilateral facet hypertrophy-without canal stenosis foraminal encroachment. 3. Mild disc degeneration and diffuse annular bulge at L1-2 and L2-3 without focal disc protrusion or stenosis. 4. Large 4 cm left renal cyst suggested as well as additional smaller bilateral renal cortical cysts as interpreted by, M.D.

On February 23, 2010, Mr. was re-validated by, D.O. Impression: 1. Cervical spine fracture treated with surgical fusion and stabilization. 2. Low back pain as a new compensable injury. Dr. recommended physical therapy for the lumbar spine as well as an ESI. X-rays revealed normal appearing sacroiliac joints. Normal appearing disk space and no evidence of instability.

On April 15, 2010, an EMG was performed of the bilateral lower extremities. Impression: EMG abnormalities suggest a bilateral S1 radiculopathy and an L5-radiculopathy on the left as interpreted by, M.D.

On April 16, 2010, Mr. was evaluated by M.D., a designated doctor. Dr. placed him at MMI with a 5% whole person impairment rating based on mild weakness of the right extensor hallucis longus, but no loss of relevant reflexes and no measurable atrophy.

On May 4, 2010, Mr. was re-validated by, D.O. He stated his neck is doing ok, but he is having increased low back pain and pain radiating to the buttock region. Dr. recommended an ESI and pain management.

On June 1, 2010, , D.O. performed a lumbar epidural steroid injection.

On June 10, 2010, Mr. was re-validated by, D.O. He stated that he had tremendous relief with his injection, about 75-80%. Dr. recommended a second ESI.

On June 23, 2010, Mr. was evaluated by, D.O. Impression: 1. Neck pain. 2. Back pain. Dr. recommended a chronic pain management program.

On July 21, 2010, , M.D., an orthopedic surgeon performed a peer review. Dr. He determined that the physical performance test dated 6/23/10 was reasonable and necessary. Mr. is not a candidate for chronic pain management program and no additional treatments are necessary for the lumbar spine.

On June 18, 2010, , M.D. a preventative medicine specialist, performed a utilization review on the claimant. Rational for Denial: The claimant is only 2 weeks out from the initial caudal ESI. There is report of improvement but no way to determine if there is going to be lasting benefit. ODG guidelines recommended repeat injections only when there is 6-8 weeks of significant objective benefit. Therefore, it is not certified.

On July 6, 2010, , M.D. an orthopedic surgeon, performed a utilization review on the claimant Rational for Denial: ESI is repeated for good results no longer than 6-8 weeks. The prior denial was appropriate and should be upheld. Therefore, it is not certified.

**PATIENT CLINICAL HISTORY:**

On xx/xx/xx, the claimant was involved in a rollover accident, was taken to an emergency room where a laceration to this knee was suture. Thereafter he had complaints of pain in his neck, shoulder, back, and right leg.

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

Upon reviewing the medical records and previous determinations the previous decisions are upheld. Based on the ODG Guidelines: 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](#)) The claimant did not receive 50-70% pain relief from the first ESI; therefore, a 2<sup>nd</sup> ESI would not be medically necessary.

**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.

(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- 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)