



Notice of Independent Review Decision
REVISED REPORT
 Omitted injured worker's name and address

Initial Report: March 25, 2010
 Revised Report: March 26, 2010

REVIEWER'S REPORT

DATE OF REVIEW: 03/23/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:
 Epidural pain block, L4/L5 and L5/S1

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
 D.O., duly licensed in the State of Texas for the practice of medicine, Fellowship Trained in Pain Management and Board Certified in Anesthesiology with Certificate of Added Qualifications in Pain Medicine, with over 22 years in the active and current practice of Pain Management

REVIEW OUTCOME:
 Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
724.2	64483		Prosp.						Upheld
338.28	64484		Prosp.						Upheld

- INFORMATION PROVIDED FOR REVIEW:**
- TDI case assignment.
 - Letters of denial dated 01/22/10 & 02/16/10, including criteria used in the denial.
 - Progress notes 10/27/04 through 01/29/10.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
 No information was provided regarding any details of the claimant's initial injury of xx/xx/xx. It was stated the claimant felt pain in her lower back while pushing a box. On 08/20/03 the claimant underwent L3/L4, L4/L5, and L5/S1 laminectomy with decompression, L3/L4, L4/L5, and L5/S1 bilateral facetectomy and foraminotomy, exploration of L4/L5 and L5/S1 fusion, bilateral intertransverse fusion at L3/L4, L4/L5, and L5/S1 with bilateral posterolateral fusion using bone graft and hardware. Progress notes from the surgeon, which are all handwritten and, for the most part, illegible, indicate that the claimant continued to have the same complaints of low back and, intermittently, left leg pain from 01/05/05 through 01/19/10. Other than

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continued refills of Ultracet, naproxen, and Theragesic cream, as well as trials of other anti-inflammatory medication including Vioxx.

There is no documentation of any other treatment attempts. For the five years documented in these progress notes, the only significant change noted is that the claimant's weight increased from 224 pounds to its current 274 pounds. Additionally, according to the physician reviewers, the claimant had an MRI scan of the lumbar spine on 09/28/09, demonstrating stable alignment and posterior spinal fixation from L3 through S1 with a small left posterior disc osteophyte complex at the L2/L3 level with left facet hypertrophy and moderate left foraminal narrowing. None of the progress notes provided document any plan for epidural steroid injections throughout the five years of notes provided and reviewed.

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

According to ODG Treatment Guidelines, epidural steroid injections are medically reasonable, necessary, and indicated if there is either examination of electrodiagnostic study evidence of radiculopathy, which is corroborated by MRI scan findings of disc herniation and nerve root compression consistent with the clinical symptoms. Additionally, epidural steroid injections are considered medically reasonable and necessary if more conservative treatment such as exercise and physical therapy have failed.

In this case, there is no evidence of any trials of conservative treatment, nor is there any evidence of either physical examination or electrodiagnostic evidence of radiculopathy nor of MRI scan evidence of disc herniation with nerve root compression corresponding to the claimant's subjective pain complaints. Therefore, per ODG Treatment Guidelines, there is no medical reason, necessity, or indication for any epidural steroid injections. Additionally, this claimant has undergone lumbar fusion from L3 through S1 with no evidence of any recurrent or residual disc herniation at L4/L5 or L5/S1 or any evidence of nerve root compromise or compression at either L4/L5 or L5/S1. Therefore, according to ODG Treatment Guidelines and the fact that the claimant has been fused from L3 through S1 with no evidence of recurrent or residual disc pathology or nerve root compromise, there is no medical reason or necessity for the requested epidural pain blocks at L4/L5 and L5/S1. Therefore, the recommendations of the two previous physician advisers for non-authorization of the requested procedure are upheld as appropriate. The request for epidural pain block at L4/L5 and L5/S1 is not supported by evidence-based peer reviewed guidelines nor medical standards of care.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description).