



Notice of Independent Review Decision  
**IRO REVIEWER REPORT**

**DATE OF REVIEW:** 4/29/10

**IRO CASE #:**                      **NAME:**

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

Determine the appropriateness of the previously denied request for bilateral lumbar epidural steroid injections (ESIs) at L3-4 with fluoroscopy. CPT codes: 64483, 64484 and 77003.

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

Texas licensed anesthesiologist

**REVIEW OUTCOME:**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- |  |                                  |
|--|----------------------------------|
| <input type="checkbox"/> Upheld                          | (Agree)                          |
| <input type="checkbox"/> Overturned                      | (Disagree)                       |
| <input checked="" type="checkbox"/> 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.

The previously denied request for bilateral lumbar ESIs at L3-4 with fluoroscopy. CPT codes: 64483 and 64484.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Request Fax dated 4/19/10.
- UR Findings dated 4/8/10, 3/14/10.
- Consultation dated 3/16/10, 3/2/10, 2/16/10, 1/19/10, 1/5/10, 12/22/09, 12/8/09, 9/15/09, 9/1/09, 6/16/09.
- Doctors Report date 1/27/10, 9/29/09, 9/15/09, 7/7/09, 6/25/09, 6/16/09, 6/1/09, 5/28/09, 5/15/09, 5/12/09.
- Follow Up dated 3/4/10.
- Prescription Sheet dated 12/22/09.
- Physicians Report dated 12/22/09.
- Evaluation Report dated 8/19/09.
- Office Consultation dated 8/14/09, 8/5/0.

- Office Note dated 7/28/09.
- Operative Report dated 7/2/09.
- Lumbar Spine MRI date 8/31/07.
- Request for Lumbar ESIs (date unspecified).
- Authorization Fax (date unspecified).
- Guidelines (date unspecified).

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:** Gender: Male

**Date of Injury:** xx/xx/xx

**Mechanism of Injury:** Fall from a tractor.

**Diagnosis:** Displacement of intervertebral disc.

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

This male sustained a low back injury, on x/xx/xx, when he fell off of a tractor. His diagnosis was displacement of intervertebral disc. He had an MRI performed on 8-31-07 and a CT myelogram performed 8-14-09, which were notable for a 3mm disc bulge at L3-4, L4-5, and L5-S1, with minimal foraminal stenosis noted at these levels. The myelogram was notable for severe bilateral foraminal stenosis at the L3-4 and L4-5 segment. An electromyogram / nerve conduction velocity study (EMG/NCV) was notable for an L5 right radiculopathy. The treatment history consisted of medication management and physical therapy (PT). There also was an ESI performed at the L4-5 segment, by Dr., without benefit. There was a subsequent right selective nerve root block performed on 7-02-09, at the L3-4 segment with local anesthetic only. This was reported to have provided a 100% benefit. The procedure was for diagnostic purposes, but the surgeon, Dr., did not feel the patient was a surgical candidate. There was a subsequent request for an ESI at that level. It was denied on peer review. The ODG criteria for the use of ESIs are as follows: “(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. (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. (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. There is recommendation for no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.” In this patient there was only one ESI performed at the L4-5 segment without benefit. There was a subsequent selective nerve root block (SNRB) on the right, without steroid, performed at the L3-4 segment, on 7-02-09, which provided 100% benefit for the duration of the local anesthetic. There was no documentation or operative note indicating a left L3-4 SNRB was performed. Since the patient has not had an ESI at the L3-4 segment and there was documentation of radiculopathy by diagnostic studies which correlated with the physical examination findings, the previous adverse determination is partially overturned. The request is considered medically necessary for a right L3-4 ESI only. CPT codes 64483 and 64484 are partially overturned. Code 64483 is approved for the right L3-4 level only.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE.
- AHCPH – 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.  
Official Disability Guidelines (ODG), Treatment Index, 8<sup>th</sup> Edition (web), 2010, Low back – ESI therapeutic.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).