



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 05/14/10; AMENDED : 05/17/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral L5-S1 Transforaminal Epidural Steroid Injection With Fluoroscopy

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

Board Certified in Physical Medicine & Rehabilitation

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.

Bilateral L5-S1 Transforaminal Epidural Steroid Injection With Fluoroscopy
– UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Lumbar Spine X-Ray, M.D., 09/23/08
- Evaluation, M.D., 09/29/08, 10/13/08, 11/03/08, 11/20/08, 12/18/08, 02/02/09, 03/30/09, 04/20/09
- Consultation, Unknown Provider, 09/30/08
- Chart Notes, Unknown Provider, 09/30/08, 10/02/08, 10/06/08, 10/08/08, 10/10/08, 10/13/08, 10/15/08, 10/17/08, 10/21/08
- Initial Report, D.C., 09/30/08
- Follow Up Report, Dr. 10/13/08
- Lumbosacral Spine MRI, M.D., 10/20/08
- Cervical Spine X-rays, Dr. 11/13/08
- Evaluation, M.D., 12/01/08, 12/22/08, 01/12/09, 02/09/0904/13/09, 05/11/09, 06/22/09, 07/27/09, 10/12/09, 11/16/09, 03/01/10
- Cervical Spine MRI, Dr. 12/16/08
- Bilateral L5-S1 Epidural Steroid Injection (ESI), Dr. 01/09/09
- Functional Capacity Evaluation (FCE), O.T.R., 01/16/09
- Evaluation, M.D., 02/13/09
- Notes, Ph.D., 02/20/09, 03/01/09, 03/20/09, 03/25/09, 04/01/09, 04/08/09, 04/15/09, 04/22/09, 04/30/09, 05/14/09, 06/03/09
- Medication Note, Dr. 03/02/09
- Initial Examination, O.T.R., 03/13/09
- Physical Performance Evaluation (PPE), 03/13/09, 04/01/09, 04/30/09
- Evaluation, Pain Care, 03/13/09, 04/30/09
- Chronic Pain Management, Pain Care, 03/24/09, 03/26/09, 03/27/09, 03/30/09, 03/31/09, 04/14/09, 04/20/09, 04/21/09, 04/24/09, 04/27/09, 04/28/09, 05/01/09, 05/04/09, 05/05/09, 05/06/09, 05/08/09
- Mid Term Update, Pain Care, 04/01/09
- Required Medical Evaluation (RME), 04/02/09
- Certificate of Medical Necessity and Prescription, Dr. 05/08/09
- Records Review, M.D., 05/19/09
- Rapid Assessment of Drug Adherence Report, xxxxxx, 10/12/09
- Denial Letter, Inc., 03/16/10, 04/02/10
- Correspondence, Dr. 03/25/10
- Designated Doctor Evaluation (DDE), M.D., 04/01/10
- Handwritten Report, Unknown Provider, Unknown Date
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

On the date of injury, the patient was at work when some boxes fell on the patient's back. Lumbar spine x-rays were accomplished which were described as "normal." Shortly after, the patient was diagnosed with a lumbar strain and provided a prescription for Soma and Mobic. The claimant then treated with a chiropractor. A lumbar MRI scan

disclosed findings consistent with “minimal” desiccation at the L5-S1 disc level. Cervical spine x-rays revealed findings consistent with “mild multilevel spondylosis.” It was recommended that the patient receive treatment in the form of a bilateral L5-S1 transforaminal epidural steroid injection. A cervical MRI scan disclosed findings consistent with multiple levels of cervical spondylosis with “mild” disc bulges the C3-C4, C4-C5, C5-C6, and C6-C7 disc levels. It was then recommended that the patient be maintained on the following prescription medications: Norco, Lyrica, Senokot, and Robaxin. It was recommended that the claimant receive access to treatment in the form of a left C6-C7 transforaminal epidural steroid injection. The patient then received a right L5-S1 transforaminal epidural steroid injection. The patient then received at least sixteen sessions of treatment at Premier Pain Care in the form of a comprehensive pain management program. The patient was then placed at Maximum Medical Improvement as of 04/02/09 with a total body impairment of 0%. The patient was not participating in work activities and it was recommended that the patient receive access to treatment in the form of a lumbar epidural steroid injection. A lumbar epidural steroid injection provided to the patient in January 2009 provided a reduction of pain by approximately 80% for two to three weeks and it was again recommended that the patient receive access to treatment in the form of a bilateral L5/S1 epidural steroid injection. The patient was maintained on prescriptions for Norco, Lyrica, Lunesta, and Zanaflex.

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

Based upon the records available for review, per criteria set forth by the Official Disability Guidelines, medical necessity for treatment in the form of a bilateral L5-S1 epidural steroid injection would not appear to be established. Official Disability Guidelines would not support the medical necessity for treatment in the form of lumbar epidural steroid injection for the following reasons: (a) a lumbar MRI scan obtained on 10/20/08 did not reveal any findings worrisome for a compressive lesion upon any of the neural elements of the lumbar spine; (b) there were findings on physical examination notable for the presence of positive Waddell’s testing by more than one physician; (c) the patient was placed at a level of Maximum Medical Improvement (MMI) and awarded a 0% whole person impairment rating by the Designated Doctor on 04/02/09. A designation of MMI generally indicates that ongoing medical care would not be expected to enhance the physical status of an individual; (d) there are no consistent findings on physical examination amongst physicians who evaluated the patient; (e) there was insufficient amount of pain resolution from a lumbar epidural steroid injection performed on 01/09/09 to support a medical necessity for a repeat lumbar epidural steroid injection. There was not a significant enough of a response to a previous attempt at a lumbar epidural steroid injection to support a medical necessity for a repeat lumbar epidural steroid injection.

Consequently, per criteria set forth by the above-noted reference, the submitted documentation would not support a medical necessity for a lumbar epidural steroid injection as defined per criteria set forth by the above-noted reference.

**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)