

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 11/09/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L5-S1 Epidural steroid injection (ESI) to include CPT codes: 62311, 77003, 72275, 62264

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the L5-S1 Epidural steroid injection (ESI) to include CPT codes: 62311, 77003, 72275, 62264 is medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 10/29/10
- Decision letter– 10/05/10, 10/14/10, 10/19/10
- Letter from Utilization Management – 11/01/10
- Physician Review Recommendation – 10/05/10, 10/19/10
- Procedure orders from Dr. – 09/30/10
- Orthopedic Report by Dr.– 03/02/10 to 09/27/10
- Report of ROM and Muscle tests – 09/27/10
- Report of x-rays of the lumbar spine – no date
- MRI of the lumbar spine – 01/25/10
- Operative report of lumbar epidural steroid injections by Dr. – 04/23/10, 08/13/10
- Copy of article from The Journal of Bone & Joint Surgery, Vol 89-A, Supp 3, 2007, “The Current State of Cervical And Lumbar Spinal Disc Arthroplasty”
- Copy of article from Spine J. 2004 Sep-Oct; 4(5): 495-505 “The effect of spinal steroid injections from degenerative disc disease”
- Copy of article from Semin Roetgenol 2004 Jan;39(1):7-23 “Epidural steroid injections”
- Copy of article from The Journal of Bone and Joint Surgery (American).2006;88:1722-1725. “Nerve Root Blocks in the Treatment of Lumbar Radicular Pain” “A Minimum five-Year Follow-Up”
- Partial copy of Guides to the Evaluation of Permanent Impairment Box 15-1 *Definitions of Clinical Findings Used to Place an Individual In a DRE Category*

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury when he was lifting a 50 pound bag of flour and felt immediate pain in his low back pain. He also experienced numbness and tingling down into his left foot. The patient has been treated with physical therapy as well as 2 lumbar epidural steroid injections.

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

This patient had back surgery in December of 2009. Since that time he has had an MRI which confirms the presence of disc protrusion at L5-S1 left and his symptoms and findings are consistent with L5-S1 left. The patient has had two epidural steroid injections with improvement. The last injection on 08/13/10 had 80% improvement when he was last seen on 09/27/10. This is well within the guidelines of the ODG. ODG Guidelines do not state that more than two injections should not be given, but that a routine series should not be done. The

additional injections should be condition based with demonstration of improvement at 6-8 weeks. This is the case with this patient who does not desire surgery and the third injection may indeed avoid the surgery. This is within the ODG guidelines and is determined to be medically necessary.

**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
- 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
- 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)