



Notice of Independent Review Decision

DATE OF REVIEW: 10/22/10

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for epidural steroid injection (CPT codes 62311, 77003).

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

Texas licensed, board-certified anesthesiologist with added qualifications in pain medicine

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.

The previously denied request for epidural steroid injection (CPT codes 62311, 77003).

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Prescription Copy dated 9/27/10.
- Re-Examination dated 9/20/10.

- Notice of UR Findings dated 8/26/10.
- Follow Up Visit dated 8/17/10.
- Procedure Note dated 8/2/10.
- Initial History and Physical dated 7/8/10.
- Exam Results dated 5/28/10.
- Lumbar Spine MRI dated 8/28/09.
- Preauthorization Request (date unspecified).
- There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: The patient was hit in the lower back by a pipe that resulted in a L4-5 anterior subluxation and foraminal stenosis.

Diagnosis: Low Back Pain with Lumbar Radiculopathy

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

This male was injured on xx/xx/xx. The mechanism of injury occurred when he was hit in the lower back by a pipe. He had with a diagnosis of low back pain with radiculopathy. On 8/28/09 the patient had an MRI that revealed a 5mm anterior subluxation at L4-5 causing left greater than right foraminal stenosis. There was an electromyogram/nerve conduction velocity (EMG/NCV) study completed on 5/28/10 that was notable for a bilateral L4 radiculopathy and a left L5 radiculopathy. There was an epidural steroid injection (ESI) performed on 8/2/10. There was noted "excellent" response, and there was a request for a second injection, which was denied. There was noted a 50% continued improvement at 2 weeks. The denial was based on the therapeutic guidelines for ESIs in the ODG. In this patient, it appeared that this was the first ESI. The patient was noted to have failed conservative care with physical therapy and medications prior to the 8/2/10 ESI. That was the reason for the initial request for the first ESI. In the second on ESIs, the ODG states: "In the *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." Based on this criteria, a second ESI (CPT codes 62311, 77003) would be supported and, therefore, is medically necessary. Therefore, the previous adverse determination is overturned.

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.
- 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.
Epidural steroid injection; low back
- 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).