IRO#
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Plano, Texas 75093
Phone: (972) 931-5100
DATE OF REVIEW: 10/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Transforaminal ESI at L5-S1

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

This case was reviewed by a Texas licensed MD, specializing in Physical Medicine & Rehabilitation. The physician advisor has the following additional qualifications, if applicable:

ABMS Physical Medicine & Rehabilitation

REVIEW OUTCOME:

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

☒ Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Transforaminal ESI at L5-S1	64483, 64484, 72275	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request	TDI	17	10/04/2010	10/04/2010
2	IRO Request	TDI	3	10/05/2010	10/05/2010
3	Appeal Request	Orthopaedics	1	08/06/2010	08/06/2010
4	Claim File	Services Inc.	1	09/09/2010	09/09/2010
5	Designated Doctor Report	MD	7	08/30/2010	08/30/2010
6	Diagnostic Test	Radiological Association	2	07/16/2010	07/16/2010
7	IRO Request	TDI	1	10/04/2010	10/04/2010
8	Office Visit Report	MD	5	07/30/2010	07/30/2010
9	Office Visit Report	MD	9	06/15/2010	06/15/2010
10	Office Visit Report	Consultants	5	08/11/2010	08/17/2010
11	PT Notes	Physical Therapy	2	07/29/2010	08/25/2010
12	Initial Denial Letter	Services Inc.	6	07/16/2010	08/04/2010

13	Appeal Request	Orthopedics	1	08/06/2010	08/06/2010
14	Appeal Denial Letter	Consultants PLLC	1	09/08/2010	09/08/2010
15	Claim File	Services	2	09/28/2010	09/28/2010
16	Claim File	Services	1	09/09/2010	09/09/2010
17	Med Bill Hx	Services	5	10/07/2010	10/07/2010
18	Designated Doctor Report	MD	7	08/30/2010	08/30/2010
19	Diagnostic Test	Radiological Association	2	07/16/2010	07/16/2010
20	Office Visit Report	MD	5	07/30/2010	08/27/2010
21	Office Visit Report	MD	9	06/15/2010	07/13/2010
22	Office Visit Report	Pain Consultants	10	08/16/2010	08/30/2010
23	PT Notes	Physical Therapy	2	07/28/2010	08/25/2010
24	PT Notes	Physical Therapy	1	08/06/2010	08/06/2010
25	Initial Request	Consultants PLLC	1	08/20/2010	08/20/2010
26	Initial Denial Letter	Services	12	07/16/2010	09/13/2010
27	Initial Denial Letter	MD	4	08/25/2010	09/13/2010

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male patient with a DOI of xx/xx/xx. The records available for review document that the claimant developed difficulty with symptoms of low back pain on the date of injury xx/xx/xx, when the claimant was leaning over to tighten a valve. A medical document dated xx/xx/xxindicated that thoracic and lumbar spine x-rays revealed findings consistent with degenerative changes, and there were no findings worrisome for a fracture. A physician assessment occurred on 6/30/10. It was documented that the claimant received 3 sessions of therapy services. It was recommended that the claimant continue to receive treatment in the form of therapy services. A physician assessment was accomplished on 7/13/10. It was recommended that the claimant undergo an MRI of the thoracic spine and lumbar spine, as there were documented persistent symptoms of pain in these body regions. There were no documented neurological deficits on physical examination. A lumbar MRI was performed on 7/16/10. This study disclosed findings consistent with a minimal disc bulge at the L4-L5 and L5-S1 disc levels. The report did not document the presence of a compressive lesion upon any of the neural elements in the lumbar spine. A physician assessment was accomplished on 7/30/10. There were symptoms of low back pain. There were no documented neurological deficits on physical examination. It was recommended that a lumbar epidural steroid injection be provided to the claimant. A physician assessment dated 8/17/10 indicated again that there were symptoms of low back pain. There were no documented radicular symptoms, and there were no documented neurological deficits on physical examination. A physician assessment dated 8/27/10 did not document the presence of radicular symptoms with respect to the lumbar spine region. A Designated Doctor Evaluation was performed on 8/30/10. When this evaluation was performed, there were again no documented radicular symptoms, and there were again no documented neurological deficits on physical examination. The request for a Transforaminal ESI at L5-S1 was denied on an initial level review and upheld on appeal. This is an IRO request for a Transforaminal ESI at L5-S1.

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

Based upon the documentation presently available for review, medical necessity for a lumbar epidural steroid injection at L5-S1 is not established per criteria set forth by Official Disability Guidelines. There are no radicular symptoms noted on physical exam, in fact, the patient's neurological examination is completely unremarkable. A lumbar MRI obtained after the date of injury did not disclose the presence of a compressive lesion upon any of the neural elements in the lumbar spine. Therefore, based on the available clinical information presented in this case, and the ODG Guidelines (lumbar chapter), medical necessity for this request is not established, and I am unable to recommend authorizing the request for the lumbar epidural steroid injection at the L5-S1 level.

Criteria for the use of Epidural steroid injections:*Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.*

(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. (Andersson, 2000)

(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. (CMS, 2004) (Boswell, 2007)

(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. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.

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)**

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 10/22/2010.