

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** MARCH 28, 2011

**IRO CASE #:**

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

Medical necessity of proposed one (1) outpatient transforaminal epidural steroid injection (ESI) at the S1 level (2<sup>nd</sup> injection)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Orthopedic surgery and is engaged in the full time practice of 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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.4, 722.10	ESI		Prosp	1					Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Request for an IRO-24 pages

Respondent records- a total of 25 pages of records received to include but not limited to:

Letter 3.8.XX; URA reviewer list; request for an IRO forms; Insurance Company letters 1.5.XX, 1.31.XX; Provider records 9.23.XX-1.25.XX; Physical Therapy Plan of Care, Initial evaluation 11.3.XX; MRI Lumbar spine 10.5.XX

Requestor records- a total of 7 pages of records received to include but not limited to:

Clinic records 10.21.XX-12.23.XX; MRI Lumbar spine 10.5.XX; EMG report 9.23.XX

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The medical records presented for review begin with the first notice of utilization review findings. The request was for a second left S1 level epidural steroid injection. It was noted that the first injection provided relief on a temporary basis (no specific parameters are noted). There was no quantification of the amount of relief. It was reported that the parameters established in the Official Disability Guidelines were not met and the request was not certified.

The next record is the reconsideration and again the request for an epidural steroid injection was not certified.

The medical records from Dr. indicate that bilateral lower extremity electrodiagnostic testing was completed. The reported findings were consistent with an acute mild left S1 nerve root irritation consistent with radiculitis (not radiculopathy).

MRI of the lumbar spine dated October 5, 20XX noted a mild developmental canal stenosis, degenerative disc changes at L4/5 and L5/S1 and no evidence of a local protrusion, herniation or foraminal stenosis. Dr. completed his consultation noting severe pain with lumbar flexion. The degenerative changes on MRI are identified and it was reported that there was a lumbar radiculopathy on electrodiagnostic testing (actually this was a lumbar radiculitis) and the selective nerve root block of the S1 nerve root was undertaken.

Dr. reported that with the first trans-sacral foraminal injection there was "reasonable relief of symptoms on a temporary basis." Physical examination noted straight leg raise was negative; no evidence of nerve root tension signs, there is full power in the lower extremity. Deep tendon reflexes were all within normal limits. It was suggested that additional physical therapy be completed and that a second epidural steroid injection be done.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC’S POLICIES/GUIDLEINES OR THE NETWORK’S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

**RATIONALE:**

As noted in the Division mandated Official Disability Guidelines; epidural steroid injections are “Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition.” Further, the criteria for use for an epidural steroid injections noted that “1) Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing” and additionally noted is “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 supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year.”

The progress note 12.23.XX of Dr., clearly indicate that this parameter has not been reached. No clear documentation is noted after the first ESI injection as to amount of pain relief or duration of said relief. Add to that that there is no competent, objective and independently confirmable medical evidence of a verifiable new onset of radicular symptoms, no disc lesion and no acute exacerbation in pain to support the second ESI procedure; the ODG standards for the use of a second injection are not met. The request is not certifiable.

**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
- XX  DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX  MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX  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)