

Parker Healthcare Management Organization, Inc.

3719 N. Beltline Rd Irving, TX 75038
972.906.0603 972.255.9712 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: MARCH 31, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed one Lumbar transforaminal ESI at levels L4-5 and 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 Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation 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
722.10	64483		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Request for an IRO-18 pages

Respondent records- a total of 158 pages of records received to include but not limited to:

Request for an IRO forms; letter 3.1.XX; Clinic 1.31.XX-2.28.XX; letter 2.28.XX, 3.8.XX; letter 2.28.XX, 3.8.XX; Clinic records 11.1.XX-2.2.XX; Diagnostic report 2.1.XX; Clinic report 1.10.XX; Orthopedic note 1.3.XX; Medical Evaluations report 9.7.XX; MRI Lumbar Spine 9.28.XX; x-ray Lumbar 9.8.XX; DWC 69; MMI report 1.14.XX

Respondent records- a total of 9 pages of records received to include but not limited to: Letter 3.17.XX; ODG guidelines Low Back

Requestor records- a total of 31 pages of records received to include but not limited to:

Clinic 1.31.XX-2.28.XX; Clinic records 11.1.XX-3.2.XX; Diagnostic report 2.1.XX, Clinic report 1.10.XX; Orthopedic notes 1.3.XX-2.17.XX; Medical Evaluations report 9.7.XX; MRI Lumbar Spine 9.28.XX; x-ray Lumbar 9.8.XX;

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with a copy of the non certification of request as provided by Dr.. The notes reflect that there was back pain with left leg symptoms. There was a decreased range of motion and the MRI dated September 28, 20XX did not demonstrate any evidence of nerve root compromise. The prior epidural steroid injection noted 50% pain relief for 90 minutes, but there was no noted response beyond that initial window. The request was not certified. A reconsideration request was also not certified, essentially for the same set of facts.

The follow-up progress notes dated February 2, 20XX note ongoing complaints of intermittent low back and left leg pain. There was a reduced lumbar spine range of motion and straight leg raising was positive. Additional physical therapy after the first injection was outlined.

Dr. completed an orthopedic evaluation on February 17, 20XX. Again, it was noted that the epidural steroid injection gave significant improvement only "temporarily." There is ongoing back and left leg pain. The procedure note, dictated by Dr., indicated 50% pain relief for 90 minutes only.

Electrodiagnostic studies noted a change consistent with radiculitis and not a radiculopathy. The lumbar spine series noted degenerative changes at the L5/S1 level. The paravertebral soft tissues were reported as normal. The MRI dated September 20, 20XX noted degenerative disc disease, degenerative facet disease and no evidence of nerve root compromise. There was no spinal canal stenosis identified.

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 ESI's have not been found to be as beneficial a treatment for the latter condition." Further, the criteria for use for an epidural steroid injection 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 notes of Dr. and the procedure note of Dr. clearly indicate that this parameter has not been reached. Add to that here is no competent, objective and independently confirmable medical evidence of a verifiable radiculopathy, no disc lesion and no electrodiagnostic data to support the 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)