

SENT VIA EMAIL OR FAX ON  
Aug/19/2011

## IRO Express Inc.

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/19/2011

**IRO CASE #:**

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

Lumbar Epidural Steroid Injection under Fluoroscopy with Intravenous Sedation

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

Anesthesiology

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a male whose date of injury is xx/xx/xx. He reportedly hurt his back while shoveling as an xx working. A twisting mechanism of injury was described. The injured employee noted intense pain which only got worse later as the day went on. He reportedly underwent physical therapy and rehabilitative efforts, but back pain continues. MRI of lumbar spine dated 06/06/11 revealed a broad 2 mm disc bulge at L4-5 with no canal stenosis or foraminal encroachment. There was no facet hypertrophy or ligamentum flavum identified.

Facet joint effusions were appreciated. At L5-S1 there is a broad 2 mm disc protrusion with no canal stenosis or foraminal encroachment. There was no facet hypertrophy or ligamentum flavum thickening identified. There were facet joint effusions noted. Physical examination reported the injured employee to be a well developed 6'1" 205 male in moderate distress. He walks with antalgic limp and cane support device. Neuromusculoskeletal examination revealed moderate lumbar interspinous tenderness with decreased flexion at 60 degrees and reproduction of back pain complaints. He had moderate left greater than right facet tenderness that was aggravated with side bending. He had moderate left sciatic notch tenderness with mild positive straight leg raise at 60 degrees. Pinprick to sensation was preserved. Toes were downgoing. The patient was recommended to undergo epidural steroid injections.

A utilization review determination dated 07/19/11 noted that medical necessity was not established for lumbar epidural steroid injection under fluoroscopy with intravenous sedation. It was noted the claimant sustained a twisting injury to low back, with ongoing persistent back pain, left buttock pain, left leg pain, associated with numbness and tingling. He currently is using Clonazepam, Tramadol, Lexapro, and Hydrocodone. He is participating in physical therapy. MRI of lumbar spine performed on 06/06/11 documents disc bulging at L4-5 and L5-S1 disc protrusion. Physical examination on 06/29/11 documents the claimant walks with antalgic limp and cane support device. There is moderate lumbar interspinous tenderness with decreased flexion at 60 degrees and reproducing of back pain and complaints; claimant has moderate left greater than right facet tenderness aggravated with side bending, moderate left sciatic notch tenderness, mild positive straight leg testing at 60 degrees, pinprick sensation was preserved, and toes were downgoing. It was determined that the request for epidural steroid injection at unspecified level under fluoroscopy with IV sedation was not medically indicated or supported under peer review guidelines. Peer review literature indicates that radiculopathy must be objectified on physical examination findings and corroborated by imaging studies. Imaging studies do not corroborate any nerve root depression, nor are there clinical radicular findings on physical examination of weakness, atrophy, or loss of reflex. The claimant should be clearly stated to be unresponsive to medications, exercise, and / or physical therapy and no more than 2 nerve root levels should be injected using transforaminal blocks. As the claimant has not met criteria for epidural steroid injection therapy, the request is not medically supported.

A reconsideration / appeal request was reviewed and adverse determination rendered on 07/29/11. The non-certification rationale was based upon the following reasons: 1) the MRI was negative for nerve root encroachment. As cited in the guidelines, criteria for use of epidural steroid injections requires radiculopathy that must be corroborated by imaging studies and / or electrodiagnostic testing. That is not the case with this claimant. The claimant does not meet criteria for epidural steroid injection; 2) the 06/29/11 examination did not establish objective evidence of focal neurologic deficit such as motor or sensory deficits in nerve root distribution that would cause concern for radiculopathy stemming from lumbar spine.

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

Based on the clinical information provided, medical necessity is not established for lumbar epidural steroid injection under fluoroscopy with intravenous sedation. The injured employee is noted to have sustained a twisting injury to low back on xx/xx/xx. He reportedly was treated with physical therapy, but no comprehensive history of nature and extent of therapy was documented with the total number of sessions of therapy completed, modalities employed, and response thereto. MRI of lumbar spine revealed broad 2 mm disc protrusion at L4-5 and L5-S1 with no canal stenosis or foraminal encroachment. There was no evidence of nerve root compression. Physical examination revealed no evidence of motor, sensory or reflex changes. Straight leg raise reportedly was positive on the left; however, there was no indication at what degree straight leg raise became positive and if it caused back pain only or included pain radiating to lower extremity to level of knee. ODG guidelines

reflect that criteria for epidural steroid injection required radiculopathy must be documented with objective findings present on examination, and radiculopathy must be corroborated by imaging studies and / or electrodiagnostic testing. There also should be evidence the claimant has been initially unresponsive to conservative treatment. The clinical data provided does not meet criteria as specified above. Consequently, medical necessity is not established. The previous denials were correctly determined and should be upheld on IRO.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)