



## Notice of Independent Review Decision

**DATE OF REVIEW:** 11/30/11

**IRO CASE #:**

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

Lumbar Epidural Steroid Injection at L5-S1 62311 77003

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

Board Certified in Physical Medicine & Rehabilitation

### **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.

Lumbar Epidural Steroid Injection at L5-S1 62311 77003 – UPHELD

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Office Visit, M.D., 12/03/09, 03/18/10, 04/01/10, 04/07/10, 04/08/10, 04/29/10, 05/27/10, 07/01/10, 07/29/10, 08/26/10, 09/30/10, 10/28/10, 12/02/10, 01/06/11, 04/07/11, 06/16/11, 04/28/11, 09/15/11, 10/20/11
- Initial Consultation, M.D., 01/21/10
- Operative Report, Dr. 02/11/10, 03/11/10
- Follow Up Consultation, Dr. 02/18/10, 03/19/10
- Lumbar MRI, Upright MRI 03/25/10, 05/03/11
- Initial Office Visit, M.D., 04/13/10
- Initial Consultation, M.D., 04/24/10
- Operative Report, Dr., 05/17/10
- Office Visit, Dr., 06/01/10
- Office Visit, Dr. 06/15/10, 07/20/10, 01/27/11
- Electrodiagnostic Study, M.D., 07/15/10
- Evaluation, M.D., 09/21/10, 11/11/10, 01/06/11, 08/01/11, 09/12/11, 10/10/11
- Operative Report, Dr. 10/22/10, 08/26/11, 09/23/11
- New Patient Evaluation, M.D., 04/26/11
- Evaluation, 05/24/11
- Pre-Authorization, Dr. 08/09/11, 10/12/11
- Denial Letters, 10/14/11, 10/28/11
- The ODG Guidelines were not provided by the carrier or the URA.

### **PATIENT CLINICAL HISTORY (SUMMARY):**

The patient was injured on and continued to have low back pain. In February 2010, a left S1 joint block was performed. A second procedure was performed in March of 2010. An MRI of the lumbar spine performed in March 2010 showed a mild circumferential disc bulge at L1-L2 mildly impressing on the thecal sac. There was a mild circumferential disc bulge at L2-L3 mildly impressing on the thecal sac and producing mild bilateral neural foraminal narrowing. At L3-L4, there was a mild circumferential disc bulge which mildly indented the thecal sac. There was a moderate circumferential disc bulge at L4-L5 mildly impressing on the thecal sac, as well as L5-S1. Epidural steroid injections (ESIs) were performed at the left L5 and left S1 on 05/17/10. Electrodiagnostic testing was performed in July 2010, which was normal. Additional bilateral L5-S1 and bilateral S1-S2 ESIs were performed on 10/22/10. A second MRI of the lumbar spine performed in May 2011 was essentially unchanged when compared to the MRI of March 2010. Due to continued pain, L4-L5 and L5-S1 facet injections were requested.

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

Based upon the reviewed medical records, the proposed lumbar epidural steroid injection under post-operative guidance is not reasonable and necessary. There is neither documentation of active radiculopathy nor any corroborating evidence on MRI scan or

EMG study to support this treatment. The treating physician, Dr., indicates that this is being proposed only because the sacroiliac joint injection done previously has failed. This is not a valid reason, according to Evidence-Based Official Disability Guidelines, and, therefore, is not medically reasonable or necessary.

**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)
- AMA GUIDES 5<sup>TH</sup> EDITION