

# The DYLL REVIEW

We take the worry out of Peer Reviews

25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-443

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## Notice of Independent Review Decision

**DATE OF REVIEW: 05/31/2011**

**IRO CASE #:**

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

ESI, left transforaminal at the L4-5 level with sedation (64483, 77003-26, 99144)

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

**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.

The request for preauthorization of the left transforaminal ESI at L4-5 was denied, and at this point in time, based on the documents reviewed I would recommend upholding the original denial

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records Received: 16 page fax 05/11/11 IRO request, Two faxes 49 & 92 pages 05/13/11 URA response to disputed services including administrative and medical records

The documentation that was provided for this review does not indicate whether or not the current condition after is considered a new injury as there was a specific fall early in or whether this represents a continuation of his older injury

**PATIENT CLINICAL HISTORY [SUMMARY]:** According to the medical records that were provided, primary records from Provider from 2008 through the

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present, February 2011. The patient had an original injury dating back to XX/XX/XX. The patient had recently been evaluated in 2010 and request made at that point in time for invasive pain management techniques. The patient did undergo facet injection, which appeared to have offered some degree of relief.

The patient during the latter part of 2010 had request for transforaminal ESI on the left side (64483, 77003-26, 99144). It would appear from the records that this request was denied.

The patient was seen in follow-up on 02/21/11 noting that the patient had sustained a new injury in the earlier part of XX/XXXX at work. It was reported that he slipped and fell taking a hard fall after slipping on some ice. He was reported to have fallen backwards and landed flat on his back with immediate pain in his lower back radiating into the left leg. He indicated that prior to this injury he was managing his pain with only one Lyrica in the morning and one Lyrica in the evening, and this would control his pain. He was not consuming any hydrocodone until his fall. He indicated that he had had some control over his pain and was doing well. However, following this fall early in XX/XXXX, it was noted that he had exacerbated his pain into the leg and had made it quite a bit worse. He indicated that he was also suffering with neck pain as well as bilateral thumb pain.

At the time of his 02/21/11 evaluation, he noted that the lower back seemed to be bothering him the most, especially with radiating pain into the leg. He had resumed taking his hydrocodone to attempt to get some relief. He was continuing to attempt to work. It was indicated that under "Impression," he had increased lower back pain and left leg pain after a fall that occurred the beginning of XX/XXXX along with severe stenosis and hypermobility without anterior and posterior listhesis at L4-5.

The treatment plan at that point on 02/21/11 was to undergo a transforaminal injection on the left at L4-5, especially since he had had an increase in his leg pain after the recent new injury falling outside. He was to be seen in follow-up following the injection.

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

Based on the *ODG* section for epidural steroid injection for the lumbar spine, the criteria are not met. Based on the clinical examination the patient had 02/21/11, this was a new injury (an exacerbation of his prior relatively asymptomatic status) and had not undergone any non-injection treatment other than to resume some medications. The applicable section of the *ODG* "Epidural Steroid Injection" is below.

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## ODG “Epidural Steroid Injection”

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, reduction of medication use 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. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
- (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 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. (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.

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(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.

(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

## **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)