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Notice of Independent Review Decision

DATE OF REVIEW: JUNE 14, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right L5-S1 transforaminal ESI (64483,77003)

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

This physician is a Board Certified Physical Medicine and Rehabilitation with over 15 years experience.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

6/1/10: M.D., an orthopedic surgeon, evaluated the claimant. PE: Sensation is intact with normal reflexes and normal muscle strength. SLR was negative bilaterally. Contralateral SLR was negative bilaterally. Diagnosis: Low Back Pain. Lumbar Radiculopathy. Medications: Lyrica 50mg, Mobic 15mg, and Opana 5mg

6/29/10: M.D., an orthopedic surgeon, re-evaluated the claimant. PE: Was unchanged. Diagnosis: Low Back Pain. Lumbar Radiculopathy. Medications: Hydrochlorothiazide 25mg, Lyrica 50mg, Mobic 15mg, and Opana 5mg.

8/3/10: M.D., an orthopedic surgeon, re-evaluated the claimant. PE: Was unchanged. Diagnosis: Low Back Pain. Lumbar Radiculopathy. Medications: Neurontin 300mg, Lyrica 50mg, Mobic 15mg, and Opana 5mg.

9/22/10: M.D., an orthopedic surgeon, re-evaluated the claimant. PE: Was unchanged. Diagnosis: Low Back Pain. Lumbar Radiculopathy. Medications: Neurontin 300mg, Mobic 15mg, and Opana 5mg.

11/5/10: M.D., an orthopedic surgeon, re-evaluated the claimant. PE: Was unchanged. Diagnosis: Low Back Pain. Lumbar Radiculopathy. Medications: Neurontin 300mg, Mobic 15mg, and Opana 5mg.

1/19/11: M.D., an orthopedic surgeon, re-evaluated the claimant. PE: Was unchanged. Diagnosis: Low Back Pain. Lumbar Radiculopathy. Medications: Flector 1.3%, Neurontin 300mg, and Mobic 15mg.

3/22/11: M.D. performed a UR on the claimant. Rationale for Denial: The MRI revealed evidence of DJD but nothing was mentioned as to the necessity for ESI's. Also, there was no documentation about claimant being a potential surgical candidate. This request is denied due to lack of documentation.

4/1/11: M.D. performed a UR on the claimant. Rational for Denial: There was no objective physical exam findings consistent with radiculopathy in the clinical notes submitted for review. Additionally, there are no imaging studies or electrodiagnostic testing results submitted for review that would support the diagnosis of radiculopathy.

PATIENT CLINICAL HISTORY:

The claimant was injured on xx/xx/xx.

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

The previous decisions are upheld, per the ODG Low Back Chapter. Submitted clinicals do not document objective evidence of radiculopathy on physical exam. Furthermore, MRI and electrodiagnostics were not submitted for review.

Per the ODG:

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.

(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)