

IRO REVIEWER REPORT TEMPLATE -WC

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Notice of Independent Review Decision

Date: 07/26/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar TF Epidural Steroid Inj. L5/S1

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

Board Certified Pain Management/Anesthesiologist

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Cover sheet and working documents
Utilization review determination dated 05/25/12, 06/19/12
LHL602. REV 05/12

Radiographic report dated 09/17/11

Office visit note dated 09/20/11, 09/26/11, 09/23/11, 10/03/11, 10/10/11, 10/17/11, 09/19/11, 10/24/11, 10/31/11, 11/07/11, 11/08/11, 11/15/11, 11/29/11, 12/08/11, 12/26/11, 01/04/12, 01/05/12, 01/17/12, 01/26/12, 02/17/12, 03/06/12, 03/19/12, 03/22/12, 04/02/12, 04/10/12, 04/16/12, 05/01/12, 05/15/12, 05/16/12, 06/06/12, 06/07/12, 06/11/12

Procedure note dated 04/27/12

Peer review dated 11/29/11

Designated doctor evaluation dated 01/10/12

Handwritten note dated 05/15/12, 06/07/12

Orders note dated 05/15/12

Functional capacity evaluation dated 02/10/12

MMT dated 10/27/11

Emergency physician record dated 09/17/11

MRI thoracic spine dated 10/04/11

MRI lumbar spine dated 10/04/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient states that she tripped on loose metal and stumbled, but did not fall. MRI of the lumbar spine dated 10/04/11 revealed 2 mm posterocentral broad based annular disc bulge at L5-S1. There is bilateral facet hypertrophic change. There is bilateral foraminal stenosis. Peer review dated 11/29/11 indicates that the patient completed a course of physical therapy. The compensable injury is noted to consist of a lumbar and thoracic sprain/strain. A recommended epidural steroid injection is not appropriate for the patient's case because the significant degenerative findings found in the thoracic and lumbar spine are unrelated to the compensable injury. Designated doctor evaluation dated 01/10/12 indicates that diagnoses are thoracic sprain/strain and lumbar sprain/strain. The patient was determined to have reached MMI as of 01/04/12 with 10% whole person impairment. The patient underwent right L4 and L5 transforaminal epidural steroid injection on 04/27/12. Progress note dated 06/07/12 indicates the patient reports 60% improvement. Physical examination on 06/11/12 notes full lumbar range of motion. Tenderness has resolved. Deep tendon reflexes are normal, sensation is normal and muscle strength is normal. Straight leg raising is negative bilaterally.

Initial request for lumbar TF epidural steroid injection L5-S1 was non-certified on 05/25/12 noting that insufficient time has elapsed since the last injection to say it was effective. The denial was upheld on appeal dated 06/19/12 noting that the patient's physical examination fails to document radiculopathy, and there is nothing in the documentation that would allow the reviewer to override the Official Disability Guidelines criteria.

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

Based on the clinical information provided, the request for lumbar TF epidural steroid injection L5-S1 is not recommended as medically necessary, and the two previous denials are upheld. The
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patient's physical examination fails to establish the presence of active lumbar radiculopathy, as required by the Official Disability Guidelines for the performance of lumbar epidural steroid injection. The patient's physical examination documents full lumbar range of motion with normal deep tendon reflexes, sensation and muscle strength and negative straight leg raising. Given the current clinical data, the requested epidural steroid injection is not indicated as medically necessary.

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Low Back Chapter

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

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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 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.)

sacroiliac blocks or