



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 10/1/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the concurrent medical necessity of transforaminal ESI, right L4-5 with fluoroscopy and monitored anesthesia.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and 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)

The reviewer disagrees with the previous adverse determination regarding the concurrent medical necessity of transforaminal ESI, right L4-5 with fluoroscopy and monitored anesthesia.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records were received and reviewed from the following parties:

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PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee sustained a work related injury on xx/xx/xx when he was struck by a heavy piece of metal. He went to surgery on 5/2/2012 for right shoulder rotator cuff repair and subacromial decompression. The postoperative shoulder rehabilitation program included physical therapy. On the Therapy Appointment Detail note dated 06/06/2012 the diagnosis codes included 847.2 lumbar strain, although records pertaining to the actual therapy modalities were

not provided for this review.

On 08/08/2012, the injured worker's case manager faxed clinical information to offices of the Consultants and made arrangements for a visit which had been approved by the adjuster. On 08/14/2012, the injured worker was seen at that xxxxx office by M.D. Based upon the injured worker's history, the findings on the physical examination, and the findings on a lumbar spine MRI (presumably the MRI dated 09/09/2011), he diagnosed 847.2 lumbar strain/sprain with 722.10 radiculopathy secondary to lumbar disc displacement. He recommended right L4-L5 transforaminal epidural steroid injection, citing physical examination findings of "pain in right L4, L5 distribution, pain with flexion, positive right straight leg raising for leg pain, decreased sensation in the right L4, L5 distribution, absent right L4, S1 reflexes, and pathology on the lumbar MRI."

On 8/20/2012, a Precertification Request was submitted for right L4-L5 lumbar transforaminal epidural steroid injection with fluoroscopy and monitored anesthesia by an on call CRNA, CPT codes 64483, 64484, and 01992. Notification of adverse determination was given 08/23/2012. The adverse determination was upheld after reconsideration on 09/04/2012.

DIAGNOSTIC STUDIES

09/09/2011: MRI, lumbar spine without contrast:

- Broad-based central disc herniation at L5-S1 with hypertrophic facet arthropathy and patent neural foramina.
- Central/right central/right subarticular disc herniation with mild hypertrophic facet arthropathy at L4-L5. Neural foramina are patent. Mild hypertrophic facet arthropathy.

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

The injured worker meets the ODG criteria for lumbar epidural steroid injections.

According to the ODG –TWC Integrated Treatment/Disability Duration Guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 09/07/12), pertaining to Epidural steroid injections (ESIs), therapeutic:

- (1) **Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.** The objective findings were summarized by Dr.. Findings on the lumbar MRI meet the criteria for the diagnostic phase of ESI injection, as cited in (4) below and in the following paragraph.
- (2) **Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).** Dr. stated that "physical therapy / NSAIDs / muscle relaxants have failed to control symptoms". The listed medication was ibuprofen 500 milligrams twice daily.

- (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.**

According to the According to the ODG –TWC Integrated Treatment/Disability Duration Guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 09/07/12), pertaining to Epidural steroid injections, diagnostic, purposes the following indications have been recommended:

- 1) To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:
- 2) To help to evaluate a radicular pain generator when physical signs and symptoms differ from that found on imaging studies;
- 3) To help to determine pain generators when there is evidence of multi-level nerve root compression;
- 4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive;
- 5) To help to identify the origin of pain in patients who have had previous spinal surgery.

Pertaining to the request for monitored anesthesia, according to the ODG Treatment Integrated Treatment/Disability Duration Guidelines, Pain (Chronic) (updated 09/21/12), pertaining to Epidural steroid injections (ESIs) sedation is not generally necessary for an ESI but is not contraindicated. As far as monitored anesthesia care (MAC) administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of post-op care. Supervision services provided by the operating physician are considered part of the surgical service provided. Therefore, the requested service is medically 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)**