



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 10/14/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of outpt lumbar ESI right L4-5.

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 Anesthesiology.

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 agrees with the previous adverse determination regarding the prospective medical necessity of outpt lumbar ESI right L4-5.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed:

- Claims Providers – undated
- LHL009 – 9/20/12
- Denial Letters – 8/7/12 & 9/10/12

- Operative Reports – 3/12/03, 5/30/06, 2/16/10, 2/11/11, 5/4/12
- Radiology Reports – 4/19/11, 4/23/04, 2/29/12
- TWC69 – 9/16/04

DDE Report – 9/23/04
Notes – 9/16/04

Pain Clinic Record – 12/15/04

Diagnostic Imaging Report – 8/23/07

IRO Report – 9/20/11

Texas Department of Insurance:
Hearing Officer Decision and Order – 2/7/12

Office Notes – 4/11/11-7/26/12

Rx History Claim – 12/13/02-7/27/12
ODG – Low Back – Lumbar & Thoracic Chapter

Records reviewed

Examination Report – 3/6/03
Office Notes – 4/7/03, 6/26/03, 8/26/03, 12/1/03, 3/1/04, 3/18/04, 4/8/04,
5/3/04, 8/2/04, 12/6/04, 4/25/05, 8/22/05, 10/17/05, 12/22/05, 5/15/06,
10/9/06, 8/23/07, 5/19/08, 8/11/08, 1/22/09, 8/6/09, 2/4/10, 8/5/10,
8/26/10, 11/4/10, 1/17/11, 4/11/11, 4/21/11, 5/11/11, 8/11/11, 9/29/11,
2/2/12, 4/12/12, 7/26/12

Radiology Report – 3/12/03, 4/7/03, 6/26/03, 8/26/03, 12/1/03, 3/1/04,
3/30/04, 8/5/10, 8/26/10, 11/4/10, 1/17/11

Discharge Summary – 3/14/03

History and Physical Examination Report – 3/12/03, 9/30/05

Operative Report – 4/23/04, 9/30/05, 4/19/11

A copy of the ODG was provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a lower back injury on xx/xx/xx. The patient underwent a PLIF L5-S1 as well as multiple subsequent ESIs. His MRI on 02/29/12 shows postoperative changes at L5-S1. At L4-L5 there is prominent disc narrowing, broad-based disc bulge causing moderate to prominent encroachment upon the anterior aspect dural sac and neural foramina. There is prominent foraminal stenosis. The patient continues to complain of severe lumbosacral pain with radicular pain down both legs, worse on the right than the left. Patient underwent right L4-L5 ESI on 05/04/12.

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

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition - Chapter: Low Back- Lumbar and Thoracic

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 the initial use of an ESI (formally referred to 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.
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 percent 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

The patient was reported as having excellent result from the injection, but objective assessment/quantification of the relief is lacking. There should be documentation of percentage of the pain relief, length of relief, improvement in function and decreased need for medication after injection. Additionally, there is no physical examination in the most recent progress note. Given the lack of documentation to indicate specific functional improvements from the previous injection, this request cannot be substantiated. As such, this request is not 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)**