IRO NOTICE OF DECISION – WC

Claims Eval

Notice of Independent Review Decision

IRO REVIEWER REPORT - WC

[Date notice sent to all parties]: 10-1-12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right lumbar transforaminal ESI w/ fluoroscopy L5 w/ monitored anesthesia

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

American Boards of Physical Medicine and Rehabilitation and Pain Management physician

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 medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Disability index score dated 3-19-12, 4-26-12, and 6-13-12.
- 6-11-12 DC., office visit.
- 6-13-12 MRI of the lumbar spine.
- Undated - Dr. Chiropractor - pre request for physical therapy x 6 visits.
- 7-3-12 MD., office visit.
- 7-25-12 Treatment plan - Unknown provider.
- Undated - precertification for therapy provided by Dr. chiropractor.
- 8-14-12 MD., office visit.
- 8-23-12 MD., provided a letter.
- 9-7-12 Letter from.

PATIENT CLINICAL HISTORY [SUMMARY]:

Disability index score dated 3-19-12, 4-26-12, and 6-13-12.

6-11-12 DC., office visit. The evaluator recommended therapy for the claimant.

6-13-12 MRI of the lumbar spine shows straightening of the lumbar spine with absence of normal lordosis. No scoliosis identified. There is congenital short pedicles mild stenosis throughout the spine; this is mild at L1-L2, L2-L3, and L5-S1. This is moderate at L3-L4 and moderately severe at L4-L5. There is minimal degenerative disc disease at L1-L2 and L5-S1. There is moderate degenerative disc disease at L3-L4 and L4-L5. At the L3-L4 level there is minimal bilateral foraminal stenosis. At the L4-L5 level, there is moderate bilateral foraminal stenosis.

Undated - Dr. Chiropractor - pre request for physical therapy x 6 visits.

7-3-12 MD., the claimant presents with low back pain since March 2012. He injured his back lifting. The claimant reports 70% leg pain and 30% low back pain. His symptoms have advanced and persisted beyond his level of tolerance. On exam, he has decreased range of motion, subjective diminished sensation to the right calf, lateral foot and right posterior calf, most closely approximating the right L5 and S1 dermatomes. He has right EHL weakness grade 4/5. He has hypoactive right Achilles deep tendon reflex. Assessment: Possible lumbar radiculopathy. The evaluator recommended the claimant see his medical care provider to rule out the possibility of a non spinal related cause for his complaints of pain and dysfunction. The claimant was prescribed with Medrol Dosepak and Lyrica. If his symptoms do not resolve, consider a right L5 selective nerve root block.

7-25-12 Treatment plan - Unknown provider.

Undated - precertification for therapy provided by Dr. chiropractor. Interim report provided.

8-14-12 MD., the claimant is a male with complaints of low back and right lower extremity pain. The pain began after a single episode of lifting at work. The claimant reports gluteus and numbness in the lateral thigh and lateral calf. On exam, the claimant has normal sensation L1 - S1, no evidence of weakness or atrophy. DTR are right patellar 0+/5, left patellar 2+/5, right Achilles 0+/5, left Achilles 2+/5. Impression: Radiculopathy secondary to disc displacement right L5 level. Recommendations: Right L5 transforaminal epidural steroid injection. The evaluator reported the claimant has decreased hypalgesia right L5 distribution, positive right SLR for leg pain, and pain with flexion. His MRI does demonstrate pathology. The claimant is to continue with medications.

8-23-12 MD., provided a letter. Chief Complaint: Low back pain. Right lower extremity pain.

9-7-12 Letter from notes contact made on 8-27-12, decision made on 8-31-12, DO., performed a UR. The evaluator noted that there was no documentation showing that the claimant does suffer from radicular pain as confirmed by imaging studies. No documentation showing that the claimant has tried and failed conservative care prior to this. The claimant has undergone some physical therapy but no documentation showing type or amount and what length of relief if any this provided. No clear documentation showing why this procedure would be beneficial to this patient.

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

Upon review of the records provided, the MRI of the lumbar spine shows an 8 mm disc protrusion at L4-5. This claimant has positive physical exam findings (the claimant has decreased hypalgesia right L5 distribution, positive right SLR for leg

pain, and pain with flexion) consistent with the MRI findings. Therefore, the request for right lumbar transforaminal ESI w/ fluoroscopy L5 w/ monitored anesthesia is reasonable and medically necessary.

Per ODG 2012 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.)

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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)**