



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 10/29/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of in office lumbar epidural steroid injection L4/L5 level on the right.

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 in office lumbar epidural steroid injection L4/L5 level on the right.

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:

Office Notes – 6/7/13, 6/11/13, 6/28/13, 7/12/13, 9/19/13, 10/4/13

Specialist Consult Slip – 5/29/13

Diagnostic Imaging/Testing Referral Slip – 5/21/13

Patient Information – 4/30/13

MRI:

MRI Lumbar – 5/28/13

Scheduling Status – 5/21/13

Injury Care DWC Subscriber – 8/30/05

Records reviewed from xxxxxx:

xxxxx:

Prospective IRO Review Response – 10/9/13

LHL009 – 10/7/13

Denial Letter – 9/11/13

Appeal Determination Denial – 10/3/13

Denial Determination Letter – 9/11/13

Denial Letters – 6/20/13, 6/21/13, 7/11/13, 9/6/13, 9/20/13, 9/26/13,
10/1/13

Case Summaries – 9/11/13, 9/24/13, 10/3/13, 10/7/13

Appeal/Reconsideration Acknowledgement Letter – 9/26/13

Adverse Determination Letter – 9/24/13

Substantial Change Assessment – 9/20/13

Appeal Determination Denial – 10/7/13

xxxxxxx:

Precertification Requests – 5/13/13, 9/6/13

Follow-up Evaluations – 7/5/12, 3/7/13, 4/4/13, 5/2/13, 7/11/13, 8/29/13

xxxxxxx:

History and Physical – 10/25/11

Diagnostic:

Lumbar Myelogram – 1/11/12

Evaluation Report – 7/27/13

Electrodiagnostic Study – 8/8/13

History and Physical – 8/8/13

Denial Determination Letter – 9/24/13

Denial Determination Letter – 10/7/13

DWC73 – dates vary

Follow-up Evaluation Report – 5/7/13, 5/14/13, 5/29/13, 6/4/13, 6/11/13,
6/25/13, 7/2/13, 8/20/13, 8/27/13

Specialist Consult Slip – 6/27/13

Prescription – 8/27/13

Physical Therapy Daily Notes – 5/28/13, 5/31/13, 6/3/13

Physical Therapy Re-Evaluation Notes – 5/31/13

Email – 7/9/13

FCE – 8/20/13

Initial WC Evaluation – 8/30/13

Scripts – 8/30/13, 9/27/13

Physical Medicine & Rehabilitation Treatment Plan – 8/30/13

Progress Note – 9/27/13

Pre-authorization Request – 9/20/13

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was injured on xx/xx/xx. The claimant suffered lumbar strain. The patient has MRI of the lumbar spine, physical therapy and oral anti-inflammatory medications. MRI dated 05/28/2013 reported a 2mm disc protrusion at L4-5 and a 5mm disc protrusion at L3-4 extending into the right lateral recess bilateral facet degenerative changes, mild right neural foramen narrowing without left neural foramen narrowing. No evidence of disc herniation or neural foraminal narrowing at the other levels. Physical examination from 04/2013 to 07/2013 reported the claimant's physical examination with deep tendon reflexes normal, sensation normal and muscle strength normal.

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

The patient's MRI shows a 2mm protrusion at L4-5 without neural compromise. Therefore, the imaging study does not support the request for epidural steroid injection at L4-5. Furthermore, clinical examination is not consistent with radiculopathy. While examination on 06/07/2013 shows decreased sensation in the right L5 dermatome, examination on 06/11/2013 shows no sensory, motor or reflex deficits. Per ODG, radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. Therefore, this request is not medically necessary.

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition

Chapter: Low Back- Lumbar and Thoracic

Epidural steroid injections, diagnostic

Recommended as indicated below. Diagnostic epidural steroid transforaminal injections are also referred to as selective nerve root blocks, and they were originally developed as a diagnostic technique to determine the level of radicular pain. In studies evaluating the predictive value of selective nerve root blocks, only 5 percent of appropriate patients did not receive relief of pain with injections. No more than 2 levels of blocks should be performed on one day. The response

to the local anesthetic is considered an important finding in determining nerve root pathology. (CMS, 2004)(Benzon, 2005)
When used as a diagnostic technique a small volume of local is used (Epidural steroid injections (ESIs), therapeutic

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.

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)**