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Notice of Independent Review Decision

DATE OF REVIEW: September 25, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

O/P lumbar ESI @ L3-4 epidurogram and anesthesia.

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

M.D., Board Certified in Anesthesiology and Pain Management.

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)

I have determined that the requested O/P lumbar ESI @ L3-4 epidurogram and anesthesia are not medically necessary for the treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 9/03/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 9/05/13.
3. Notice of Assignment of Independent Review Organization dated 9/06/13.
4. Denial documentation.
5. Document entitled Treatment History.
6. ODG Treatment Integrated Treatment/Disability Duration Guidelines: Low Back – Lumbar & Thoracic (Acute & Chronic).
7. Medical records dated 8/06/12, 11/07/12, 2/06/13 and 5/20/13.

8. Medical records dated 2/23/12, 6/07/12, 7/23/12, 8/08/12, 10/04/12, 12/20/12, 3/18/13, 6/12/13, and 9/12/13.
9. Medical records from pump refill dated 10/04/12 and 3/18/13.
10. Therapeutic drug screen dated 3/18/13.
11. Radiology report dated 6/12/13.
12. Drug profile dated 10/04/12.
13. CT scan of the lumbar spine dated 1/29/08.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with chronic pain. He reportedly sustained an injury on xx/xx/xx. On 1/29/08, computed tomography (CT) scan of the lumbar spine demonstrated fusion cages at L4-5 and L5-S1. The report noted bilateral laminectomy and facetectomy deformities at L4-5 and L5-S1, and the study remained unchanged from the previous examination. On 2/23/12, the patient reported low back pain which radiated to the left lateral thigh and right lateral thigh. He reported that he was taking his medications as instructed. Neurological examination revealed no evidence of stocking or glove sensory loss in either upper extremities or lower extremities. The documentation noted decreased motion in the spine. A pain pump was reprogrammed and refilled. On 8/08/12, the patient reported continued pain. The medical records noted that the patient recently had been prescribed methadone while in the emergency department. On 2/06/13, the patient reported that his symptoms were alleviated by his medications and morphine pump. On 3/18/13, he continued to report low back pain which radiated to the right lateral thigh. His pain pump was refilled. On 6/12/13, x-rays of the lumbar spine revealed mild to moderate degenerative changes worse in the lower lumbar spine and fusion L4 to S1 without hardware complication. The patient has requested coverage for O/P lumbar ESI @ L3-4 epidurogram and anesthesia.

The URA indicates that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Per the URA, although the records note lumbar pain with radiation to the bilateral thigh and leg, specific dermatomal deficits attributable to an L3-4 nerve root impingement were not noted. The URA noted that a definite diagnosis of radiculopathy cannot be ascertained. On appeal, the URA reported that additional records were unable to provide objective evidence of radiculopathy associated with the L3-4 nerve root to warrant an epidural steroid injection.

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

Per ODG criteria for the use of epidural steroid injections, radiculopathy must be documented. The criteria notes that objective findings on examination need to be present, and radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. Additionally, the patient must be initially unresponsive to conservative treatment, including exercises, physical methods, nonsteroidal anti-inflammatory medications, and muscle relaxants. In this patient's case, he continued to report bilateral lateral thigh pain and back pain, but there was lack of objective evidence of a specific dermatomal deficit that could be attributable to L3-4. Other than pain management, there was also a lack of documentation demonstrating that the patient was

initially unresponsive to conservative treatment, including exercises, physical methods, nonsteroidal anti-inflammatory medications, and muscle relaxants. In addition, guidelines indicate that a major cause of concern would be performing this procedure under sedation which may hinder the patient being able to demonstrate nerve root irritation. The guidelines further state that factors that decrease success include previous back surgery. All told, O/P lumbar ESI @ L3-4 epidurogram and anesthesia are not medically necessary for the treatment of this patient.

Therefore**,** I have determined the requested O/P lumbar ESI @ L3-4 epidurogram and anesthesia are not medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, 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)**