



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 7/25/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of LESI L3-4-5-S1 times 3.

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 LESI L3-4-5-S1 times 3.

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 Visit Note – 5/7/13

T-spine MRI with Contrast – 1/30/08

Radiology Diagnostic Report (MRI) – 3/5/07

Records reviewed:

Office Visit Note – 9/8/11-7/10/13

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with original injury on xx/xx/xx. His diagnosis was low back pain and lumbar radicular pain. The patient was status post 360 lumbar fusion in 2002, had removal of loose hardware in 2004, spinal cord stimulator in 2008, and placement of intrathecal pain pump in 2008. He reports low back pain and lower extremity pain. The patient has been using increased pain medications. Exam reveals motor and sensory intact in the lower extremities. The plan was for ESI at L3-S1. The patient has been on hydrocodone that has been inadequate for pain control.

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

The most recent examinations, on 07/10/2013, indicate a use of intrathecal pain pump; however, the physical examination reveals that motor and sensory exams are unchanged. In thorough review of the records there is no demonstration that a true neurological abnormality in a myotomal or dermatomal distribution consistent with diagnosis of radiculopathy. Additionally, the records did not indicate whether the patient was unresponsive to conservative measures (physical therapy, exercises, NSAIDs and muscle relaxants). Furthermore, the request is for ESIs at four levels, which is more than the number of levels that are recommended. Therefore, requested lumbar epidural steroid injection from L3-4 and L5-S1 times three is not medically necessary based on records provided.

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 on 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)**