IRO NOTICE OF DECISION – WC

Claims Eval

Notice of Independent Review Decision

March 31, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OP Right Lumbar ESI at L5/S1

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

American Board of Physical Medicine and Rehabilitation
Subcertification in Pain Medicine

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

8-5-13, performed an Impairment Rating. He certified the claimant had not reached MMI. The evaluator recommended additional physical therapy and and ESI needs to be consider.

9-3-13, the claimant complains of moderate to severe low back pain radiating pain down the right leg. Impression: Right knee lateral and medial meniscus tear repair lumber strain, chronic L4, L5, and S1 bilateral radiculopathy, lumbar disc derangement (L4-L5 and L5-S1). Plan: The evaluator will refer the claimant out to a pain management specialist for consultation regarding additional epidural steroid injections. The evaluator will submit pre-authorization request for 12 additional sessions of postoperative rehabilitation for the right knee. The claimant was prescribed Norco, Robaxin, Gabapentin. Issue a TENS unit for additional pain control.

10-21-13 Functional Capacity Evaluation shows the claimant is functioning at a Sedentary PDL.

11-21-13, the claimant complains of low back pain. The pain radiates into both lower extremities. Assessment: Lumbar radiculopathy, lumbar herniated nucleus pulposus. Plan: Per ODG, therapeutic ESI requested.

12-6-13, performed a Required Medical Evaluation. He certified the claimant had reached MMI on 9-17-12 and awarded the claimant 4% whole person impairment for the right knee. He did not agree with a 5% for the lumbar spine, as the 2 mm disc bulges would not impinge the nerves.

12-9-13 Notification of Adverse Determination:, Request for right lumbar ESI at L5-S1. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines, this request is non-certified.

12-12-13, the evaluator noted the epidural steroid injection was denied. The claimant was prescribed Baclofen.

12-30-13 Fax coversheet

1-3-14 Preauthorization Request: Claim #: xxxxx date of injury: xx/xx/xx. Lumbar epidural steroid injection L5-S1 on the right times one.

Follow-up visit on 1-9-14 notes the claimant was prescribed Neurontin and Baclofen.

1-22-14 Notification of Reconsideration Determination: Request for right lumbar ESI at L5-S1. After careful review of all available information, our Specialty Advisor has determined that the proposed treatment does not meet medical necessity guideline.

1-23-14, the claimant’s ESI was rejected by reviewer even though the claimant meets ODG. Assessment: Lumbar radiculopathy, lumbar herniated nucleus pulposusus. Plan: Per ODG therapeutic ESI requested. Criteria for 6-8 weeks

benefit of 50% or greater relief neurological deficits, imaging consistency and clinical signs are consistent. L5-S1 level, on the right, times one.

2-6-14, the claimant able to stand for less than 15 minutes. Able to sit for less than 15 minutes. Able to walk for less than 15 minutes. Pain level now 7-9/10. Pain level at the worst 7-9/10. Pain level at best 4-6/10. He notes the claimant has decreased DTR in the lower extremities, SLR positive bilaterally. Assessment: Lumbar radiculopathy, lumbar herniated nucleus pulposus. Plan: Per ODG Guidelines, diagnostic ESI is requested. Criteria for neurological deficits, imaging consistency and clinical findings are met. L4-L5 level, on the right times one. The claimant had previous transforaminal injections, he would like to request interlaminar injections as a better tool for diagnostic purposes.

2-19-14 Preauthorization Request: Claim #: xxxxx date of injury: xx/xx/xx. Lumbar epidural steroid injection L5-S1 on the right times one diagnostic.

3-5-14 Request Form.

Provider that Received the Denial.

3-13-14 Fax coversheet; to: IRO Notice of Assignment (IRO).

3-13-14 Health Care

Independent Review Portal-IRO Request Details: Your Request has been successfully submitted.

3-13-14 Notice to Claims Eval of Case Assignment.

3-14-14 Health Care; attn: Claim Eval- IRO Invoice Payment processing. Please fax invoice to Insurance dispute.

3-13-14 Notice of Assignment to Independent Review Organization: This letter is to notify you that the claimant, the claimant's representative, or the claimant's provider requested independent review by an independent review organization (IRO). The Department certifies IROs. The IRO is independent of the payor (the claimant's health plan or insurance company), the payor's utilization review agent (URA), and health care providers.

3-13-14 Notice to Utilization Review Agent of Assignment to Independent Review Organization: In accordance with Texas Insurance Chapter (TIC) 4201 and TDI rules, the carrier, if applicable, or the utilization review agent (URA) must provide to the Independent Review Organization the information or documents listed below no later than the time frame required in TIC.

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

Medical records reflect a claimant with complaints of low back pain and dull aching and numbness pain. The treating doctor is requesting an epidural steroid injection. He notes that on exam, the claimant had decreased DTR in the lower extremities, SLR positive bilaterally. Medical records reflect this claimant had an MRI of the lumbar spine that showed a 2mm disc bulge that did not impinge on the nerve roots. Based on the records provided, the claimant does not have evidence of radiculopathy that would support this request or diagnostic testing findings documenting nerve root impingement. Therefore, the request for Right Lumbar ESI at L5/S1 is not medically reasonable or medically necessary.

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 (due to herniated nucleus pulposusus, but not spinal stenosis) 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. (,) (,)

(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.)

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)**