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Notice of Independent Review Decision

Date notice sent to all parties: 02/05/14

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Translaminar epidural steroid injection (ESI) on the left at L5-S1

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Spinal Surgery

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.

Translaminar ESI on the left at L5-S1 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Lumbar MRIs dated 06/27/08 and 10/15/13
Reports dated 08/09/13 and 09/20/13
Physical therapy initial evaluation dated 08/13/13
Therapy progress note dated 10/10/13

Report, including medication agreement and information on lumbar ESI dated 11/25/13

Prescription for a compound cream dated 11/25/13

Preauthorization requests dated 11/27/13 and 12/09/13

Preauthorization report dated 12/03/13 dated 01/06/14

Notifications of preauthorization determinations dated 12/04/13 and 01/07/14

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY:

A lumbar MRI was obtained on 06/27/08. The impression was mild desiccation of the disc at L5-S1 and 3 mm. concentric disc bulge without evidence of neural foramen stenosis. examined the patient on 08/09/13. He was injured on xx/xx/xx when he felt a pop in his lower back with the sudden onset of sharp, shooting low back pain. He described severe low back pain without radiation rated at 10/10. He had tried returning to work with restrictions, but was unable to tolerate that secondary to pain. His pain was typically localized to the central low back and denied any numbness and tingling. His current medications were a Medrol Dosepak, Naprosyn, Flexeril, and Citalopram. He was a current everyday smoker. He was 70 inches tall and weighed 230 pounds. His gait was balanced and his paravertebral muscles were spasming and lumbar range of motion was normal with pain. Straight leg raising was normal bilaterally. Strength and sensory examinations were normal. X-rays revealed no listhesis or significant spondylosis. The assessment was acute low back pain likely a result of a soft tissue sprain/strain. A Medrol Dosepak was prescribed, as well as Flexeril, Naprosyn, and Citalopram. He was asked to return in three weeks and modified duty was continued. On 08/13/13, therapy was recommended twice a week for four weeks to include modalities as needed, therapeutic exercises, and myofascial therapy, as well as instruction in a home exercise program. On 09/20/13, reexamined the patient. He had received four weeks of therapy and was performing a home exercise program. He rated his low back pain at 5/10, but he denied numbness and tingling. He had some increased popping in the back with stretching. He was not working because light duty was not available. He noted relief with therapy and wanted to continue. Examination was unchanged. Continued conservative care was recommended and he was asked to return in two weeks. If he was still symptomatic, an MRI would be recommended. On 10/10/13, the physical therapist noted the patient had not had much change in his pain over the last two weeks. His disability score was 52%, which was felt to be severe. Another lumbar MRI was obtained on 10/15/13. There was a posterior disc herniation measuring 5 mm. at L5-S1 that was not present on the 06/27/08 MRI. On 11/25/13, examined the patient. He noted his low buttock pain had resolved, but he still had mid to lower back pain with intermittent radiation to the right and left paravertebral areas of the low back. He had no radiation of symptoms down the lower extremity at that time. The history and MRIs were reviewed. He reported no focal weakness or bowel or bladder dysfunction. He was noted to have chronic anxiety. Lumbar lordosis was decreased on exam and

there were no spasms. There was positive facet tenderness in the bilateral lower spine in the L5-S1 distribution. Range of motion was limited in extension and flexion. Straight leg raising was negative bilaterally. Neurological exam was normal. The assessment was a lumbar disc bulge. A transforaminal ESI on the left at L5-S1 was recommended. A topical compound cream was prescribed. On 11/27/13, provided a preauthorization request for the ESI. On 12/04/13, provided a preauthorization determination denying the requested translaminar ESI on the left at L5-S1. On 12/09/13, provided an appeal for the requested ESI. On 01/07/14, provided another preauthorization notice, denying the requested translaminar ESI on the left at L5-S1.

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

The patient has an MRI that shows disc bulging without evidence of neuroforaminal narrowing. The patient clearly has no radicular signs or symptoms, as this is clearly stated and supported by the note on 11/25/13. He states, "There is no radiation of symptoms down the lower extremity at this time." Furthermore, his neurological examination was normal that day. The current peer reviewed medical literature indicates that there is little to no efficacy in performing ESIs for axial pain. The ODG does mandate objective signs of radiculopathy for performance of an ESI and there are none based on the objective documentation reviewed. The requested translaminar ESI on the left at L5-S1 is not medically necessary or appropriate and does not meet the criteria from the ODG. Therefore, the previous adverse determinations should be upheld at this time.

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)**