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IRO REVIEWER REPORT

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IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
2nd ESI and facet injections at L4-5 and L5-S1; MRI of the left lower extremity; PT 3 X week X 6 weeks for lumbar spine; X-Ray flexion and extension L-spine; Discograms L3-S1.

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

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned	Disagree
☐ Partially Overtuned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a XXXX with a history of an occupational claim from XXXX. The mechanism of injury is detailed as XXXX. The pertinent prior treatments included physical therapy, and an epidural steroid injection. The patient underwent an L4 kyphoplasty on XXXX. The progress note of XXXX stated the patient had completed all elbow sessions of physical therapy. The pain scale was rated 8/10 with the pain 80% in the back and 20% in the legs. The pertinent current medications included tramadol, temazepam, alprazolam, and citalopram. The patient was a current daily smoker, smoking 11-20 cigarettes per day. The patient had difficulty with balance. The physical examination revealed motor strength of 4/5 on the right in dorsiflexion, plantarflexion and EHL. The patient had numbness and pain in the anterior lateral thigh to the anterior leg into the top of the foot. The patient's gait was normal. The physician note indicated the patient had an MRI of the lumbar spine on XXXX which revealed multilevel thoracolumbar scoliosis at T12-L1, previous compression fracture L4 at 40%, previous kyphoplasty L4, multiple disc herniations with degenerative disc disease T12-L1, foraminal stenosis L4-L5, L5-S1 and lateral recess stenosis L3-4. The diagnoses included lumbar spondylosis, lumbar foraminal stenosis, lumbar radiculopathy, and compression fracture of L4 lumbar vertebra with routine healing. The physician stated the back pain was greater than the lower extremity pain. The treatment plan included flexion and extension x-rays of the lumbar spine, and epidural steroid injection and facet injections L4-L5, L5-S1, physical therapy 3 times a week ×6 weeks and if no improvement, a discogram. The patient

was given smoking cessation counseling.

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

Regarding the epidural steroid injection specifically, the Official Disability Guidelines indicate that repeat epidural steroid injections are appropriate for patients who have at least 50-70% pain relief for at least 6- 8 weeks, and when there is documented functional improvement and a decreased need for pain medications for the same duration of time. The patient underwent a prior lumbar epidural steroid injection in XXXX. There was a lack of documentation indicating the patient had at least 50-70% pain relief for at least 6-8 weeks. There was no documentation of objective functional improvement and a decreased need of pain medications for the same amount of time. Regarding the requested facet injection in addition to the epidural steroid injection, the Official Disability Guidelines state that it is not recommended to perform epidural blocks on the same day of treatment as facet blocks as this may lead to improper diagnosis or unnecessary treatment and the patient should have low back pain that is non-radicular. The patient's pain and objective findings revealed radicular pain. Therefore, the second ESI and facet injections at L4-L5 and L5-S1 are not medically necessary. Regarding the MRI of the left lower extremity, the Official Disability Guidelines recommend MRIs of the lower extremities for patients who have undergone x-rays of the lower extremities that were non- diagnostic or when there was acute trauma to the knee. The rationale for the MRI was not noted. There were no specific objective findings on physical examination including specific dermatomal involvement supportive of the necessity for an MRI. Therefore, the requested MRI of the left lower extremity is not medically necessary. Regarding the requested physical therapy for the lumbar spine, the Official Disability Guidelines recommend up to 10 sessions of physical therapy for intervertebral disc disorders without myelopathy and when treatment duration and/or the number of visits exceeds guideline recommendations, exceptional factors should be noted. The physician indicated the patient had undergone the amount of allowable physical therapy. The patient should be well versed in a home exercise program. There was a lack of documentation indicating the patient had an inability to perform or had failed a home exercise program. The functional limitations were not noted. The objective functional gains made from prior therapy were not noted. There were no exceptional factors noted. As such, the requested PT 3 times a week ×6 weeks for lumbar spine are not medically necessary. Regarding the x-ray flexion and extension, the Official Disability Guidelines indicate that flexion and extension x-rays are not recommended as a primary criterion for range of motion. However, x-rays are recommended when there are red flags including lumbar spine trauma, a traumatic myelopathy or myelopathy that is either painful, sudden onset, or for an infectious disease patient or oncology patient. While the physician stated that the patient's back pain is greater than her leg pain, there are no objective findings supportive of the necessity for flexion and extension studies. There are no red flags noted. The patient was not noted to have a new injury or a form of myelopathy. There were no exceptional factors to support the necessity the requested x-ray flexion and extension of the lumbar spine. As such, the request for x-ray flexion and extension of the lumbar spine is not medically necessary.

Regarding discograms, the Official Disability Guidelines indicate that discograms are not routinely recommended. There were no objective findings supportive of the need for discogram. There were no exceptional factors to support the necessity of a discogram outside guideline recommendations. As such, the request for discograms L3-S1 are not medically necessary.

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

☐ AHRQ- 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

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Low Back Chapter, Epidural steroid injections (ESIs), therapeutic