



Notice of Independent Review Decision

DATE OF REVIEW: 5/12/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for thoracic epidural steroid injection.

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

A Texas licensed Occupational Medicine Physician.

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 or not medical necessity exists for each of the health care services in dispute.

The previously denied request for thoracic epidural steroid injection.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Confirmation of Receipt of a Request for a Review dated 5/1/08.
- Fax Cover Sheet dated 5/5/08, 5/2/08.
- Company Request for IRO dated 5/1/08.
- Request for Review by an Independent Review Organization dated 4/25/08.

- Notice of Utilization Review Findings dated 4/1/08, 3/12/08.
- Doctor's Letter dated 4/1/08, 3/12/08.
- Notice of Disputed Issue and Refusal to Pay Benefits dated 3/21/08, 3/11/08, 1/16/08.
- Notice to dated 5/2/08.
- Notice to Utilization Review Agent of Assignment dated 5/2/08.
- Follow-Up dated 4/15/08, 4/8/08, 3/19/08, 3/4/08.
- Office Visit dated 3/24/08, 3/14/08.
- Retrospective Medical Records Review dated 3/24/08.
- Cover Letter dated 5/2/08.
- Notice of Assignment dated 5/2/08.
- Report of Medical Evaluation dated 3/24/08.
- Retrospective Medical Records Review dated 3/24/08.
- Treatment Request (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Repetitive lifting, pulling and bending.

Diagnosis: Lumbar strain/sprain; herniated nucleus pulposus, thoracic spine.

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

This claimant is a xx-year-old man involved in a work related injury on xx/xx/xx. The claimant stated that he was repetitive lifting, pulling and bending at work, when he developed acute pain in the low back, neck and abdomen. Shortly after the injury, the claimant was admitted to the hospital due to unrelated medical problems. However, while there, extensive diagnostic imaging was undertaken. A CT scan of the lumbar spine was performed showing diffuse disc bulges. An MRI of the thoracic spine revealed a small right sided posterolateral herniation at the T7-8 level. An MRI of the lumbar spine revealed minimal spondylosis. The claimant was seen by Dr., who diagnosed the claimant with a lumbar strain/sprain injury and herniated nucleus pulposus in the thoracic spine. She recommended physical therapy (PT). The claimant completed 2 PT sessions with no change in status. He was referred to Dr., a neurosurgeon.

The claimant was first seen by Dr. on 2/13/08. On examination, there was slight tenderness over the cervical, thoracic and lumbar spine, with diminished cervical and lumbar range of motion, and hyperesthesia over the dorsum of the right foot and shin. The claimant was diagnosed with thoracic pain, low back pain, neck pain, T7-8 herniated disc, lumbar facet syndrome, sub-occipital headaches, and chronic pain syndrome. He ordered a thoracic epidural steroid injection. The

initial request was not approved (3/12/08). The reviewer stated that the case did not meet the ODG criteria for radiculopathy for an ESI, noting that “radiculopathy must be documented. Objective findings on exam need to be present. The diagnosis of herniated disc must be substantiated by appropriate findings on an imaging study. There must also be clinical evidence described.” The request was submitted for appeal on (4/1/08). The request was again denied. As before, the reviewer noted that there was a finding on MRI of the thoracic spine, but there was not a correlation to an active radiculopathy as documented on examination.

The request had been submitted for an IRO assessment. Dr. progress notes were reviewed. The claimant had non-specific “midback” pain, at no specific thoracic level. The examination noted he was “tender to palpation over the mid and lower back areas.” No specific pathology was identified at the T7-8 area, the area of the reported small disc herniation. There were no other objective abnormalities identified referable to the thoracic spine, and no signs or symptoms suggestive of an active thoracic radiculopathy. Notes from care through 4/15/08, with Dr. were reviewed, but the documented examination findings and subjective complaints remained unchanged, and did not document clinical findings supportive of thoracic radiculopathy. The claimant was seen by Dr. for a designated doctor evaluation on 3/24/08. The claimant’s main complaints voiced in this evaluation were back pain, with numbness at the back of the right leg, and the right leg was “dragging” when walking. Dr. noted diffuse tenderness to palpation of the thoracic spine. Dr. stated that the claimant had 7/8 positive Waddell’s signs, suggestive of non –organic pathology and symptom magnification. Dr. concluded that the claimant had reached maximum medical improvement (MMI), and could return to full duty work.

At this time, the reviewer agrees with the prior reviewers of this case. The data did not support that thoracic radiculopathy was present, as seen by several, individual reviewers. There were no objective findings present to support an active thoracic radiculopathy at T7-8. AMA Guidelines define radiculopathy as significant alteration of a nerve root. The diagnosis requires a dermatomal distribution of pain, numbness and/or paresthesias in a dermatomal distribution. None of these features are present in this claimant, based on available medical records. The ODG Guidelines state, *“Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Radiculopathy must be documented. Objective findings on examination need to be present.”* Therefore, based on the available medical records, and the clinical guidelines from ODG, the reviewer is unable to recommend authorization of the thoracic epidural steroid injection.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
- X** ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.
 - ODG Treatment Index, (web), 6th Edition, 2008, Integrated Treatment/Disability Duration Guidelines Low back – Lumbar and Thoracic (Acute and Chronic)-ESI
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).