

**PRIME 400 LLC**  
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Nevada City, California 95959

Notice of Independent Review Decision

**DATE OF REVIEW: SEPTEMBER 29, 2008**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Thoracic ESI T8-T9

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

MD, Board Certified Neurosurgeon

**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 reviewer finds that medical necessity does not exist for Thoracic ESI T8-T9.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 8/12/08, 8/20/08  
ODG Guidelines and Treatment Guidelines  
, MD, 9/4/08, 8/14/08, 8/7/08, 6/19/08, 5/22/08, 5/12/08, 4/28/08, 3/31/08, 3/17/08,  
3/6/08  
Operative Reports, 7/22/08, 5/28/08, 5/7/08, 5/2/08, 3/28/08  
Discharge Summary, 5/29/08  
History and Physical, 5/29/08  
CT Thoracic Spine, 5/2/08  
Thoracic Spine Myelogram, 5/2/08  
Lumbar Myelogram, 3/28/08  
CT Scan of Lumbar Spine, 3/28/08  
, MD, 1/28/08

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This xx year-old male has a date of injury xx/xx/xx when he was trying to remove a 95 gallon drum full of oil and was knocked to the ground and twisted his back. He complains of severe mid and lower thoracic pain and lumbar pain. He is status post L5-S1 fusion in 02/2007. He underwent exploration of the L5-S1 fusion with removal of hardware on 05/28/2008.

A myelogram and post-myelo CT of the thoracic spine 05/02/2008 reveals very minimal disc bulge at T8-T9 effacing the ventral disc space. Apparently he underwent a left T8-T9 ESI on 07/22/2008 with some benefit.

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

Based on the submitted documentation, the reviewer finds that medical necessity does not exist for Thoracic ESI T8-T9. There is no physical examination documenting a thoracic radiculopathy. The disc bulging at T8-T9 is quite mild, according to the radiology report. No nerve root encroachment is documented on the imaging studies. Lastly, the response to the prior ESI is not quantified. According to the ODG, "Low Back" chapter, there needs to be objective evidence of a radiculopathy for an epidural steroid injection to be medically necessary. Also, if a prior injection has been done, then the response should provide 50-70% pain relief for 6-8 weeks. This patient has not met ODG criteria. Based on the reasons stated above, the T8-T9 ESI is not medically necessary.

### **References/Guidelines, ODG "Low Back"**

#### **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.*

- (1) Radiculopathy must be documented. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. ([Andersson, 2000](#))
- (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 required. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of 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.
- (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 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.

**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)