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Notice of Independent Review Decision

DATE OF REVIEW: 11/25/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a lumbar spine transforaminal epidural steroid injection at L4-5/L5-S1, additional level, epidurography, fluoroscopic guidance, and sedation (64483, 64484, 72276, 76005, 99141).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a lumbar spine transforaminal epidural steroid injection at L4-5/L5-S1, additional level, epidurography, fluoroscopic guidance, and sedation (64483, 64484, 72276, 76005, 99141).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
xxx and xxxx, LLC

These records consist of the following (duplicate records are only listed from one source): Records reviewed from MD: Follow-up Notes – 12/13/07-9/9/09, Letter

of Disability – 9/17/08, Consultation – 11/15/07, Procedure Notes – 12/7/07 & 9/10/08.

Records reviewed from Texas, LLC: Denial letters – 9/4/09 & 9/29/09; Claims xxx report – 5/8/09; xxx IRO Summary – 11/11/09, Questionnaire – 12/17/08; DWC1 – 5/11/07; Exit Interview – 5/18/07; Medical Group Office Notes – 5/11/07; DC Initial Evaluation – 6/7/07; xxxx Office Notes – 6/7/07-7/17/09, Subsequent Eval – 7/17/07-9/14/09, , Subsequent Eval Amendment – 3/6/09, Process Group Session Monitoring Form – 2/11/09, xxxx Group Session Monitoring Form – 2/11/09, Chronic Pain Activity Note – 1/26/08-2/11/08, Computerized Muscle Test – 6/27/08, Behavioral Health Assessment – 8/14/07, Referral – 2/26/09, Script for EMG/NCV testing – 2/26/09, Patient Face Sheet – 2/26/09, Impairment Rating report – 6/11/09; MD MRI Report – 6/18/07; MD Office Visit Notes – 7/3/07-5/26/09, Operative Report – 2/13/08; MD MRI report – 8/2/07; MD EMG/NCS report – 8/22/07, Pre-auth request – 3/2/09, Appeal Request – 4/8/09; MD Electrodiagnostic Study – 2/6/08; Notes – 2/13/08-2/14/08; MD X-ray report – 2/13/08; Hospital Notes – 2/14/08; MD Lumbar Myelogram report – 5/7/08(x2); MD notes – 7/11/8; MD Notes – 7/31/08-8/14/08; MD Follow-up Notes – 8/4/08; MD report – 8/25/08; MD Notes – 12/8/08-2/20/09; MD Lumbar Myelogram report – 5/20/09; Post Myelogram CT report – 5/20/09; DWC69 – 5/11/09; Interventional Pain Mgt Pre-auth request – 9/1/09, Appeal request – 9/22/09.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured when she was twisting at her spine while slipping on a wet floor while on the job. She underwent a lumbar MRI on xxxxx indicating L4-5 DDD with instability and narrowing of the neural foramen bilaterally and L5-S1 foraminal HNP bilaterally. MEG/NCS by Dr. on 8/22/07 was consistent with L4, L5, and S1 radiculopathy bilaterally. She underwent an ESI by Dr. on 9/10/08. No documentation was provided regarding the patient's response t to this ESI. A repeat lumbar ESI is being requested based on radicular signs and symptoms.

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

According to the ODG: 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, 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. This criterion is met. There are diminished reflexes at the right patella and Achilles, limits in lumbar ROM, spasm, and previously abnormal EMG findings that correlate with MRI findings.

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). This criterion is met.

(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. This criterion is met.

(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. This does not apply in this case.

(5) No more than two nerve root levels should be injected using transforaminal blocks. This criterion is met.

(6) No more than one interlaminar level should be injected at one session. This does not apply in this case.

(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. In this case there is no documentation for review to assess response to initial ESI. Furthermore, none of the notes from DC at Spine and Rehab reveal any improvement after the ESI.

(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. In this case there is no documentation for review to assess response to initial ESI.

(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.)

Given that all the ODG criterion have not been met, the lumbar transforaminal ESI is not medically necessary 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)**