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Notice of Independent Review Decision

DATE OF REVIEW: 5/20/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The service under dispute includes lumbar epidural steroid injection at left L5 (CPT code 64483).

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 and 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 all services under review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Dr. 2/2508 to 4/16/09 office notes by Dr. various DWC 73 reports and lumbar MRI report of 2/7/08.

: 5/4/09 report by, 3/11/09 denial letter, 4/6/09 denial letter, 5/4/09 IRO summary, Form 1 10/1/07, 3/20/08 dispute form, associate statement 10/1/07, 10/1/07 to 2/1/08 occ med notes, radiology report of 10/10/07, 11/29/07 progress notes,

11/7/07 pt eval, 3/17/08 report by DO, 5/4/08 review, 6/6/06 DWC 69, 8/12/08 FCE, 8/7/08 DD report, 10/15/08 report by Dr. 11/14/08 letter of clarification, 12/5/08 letter by, 8/7/08 DWC 69, 1/20/09 report by, 2/19/09 ESI script, pre auth request form 3/5/09, 3/20/09 letter by, 3/23/09 letter by Dr. 4/7/09 DWC 69 and report and 4/17/09 letter.

We did not receive a copy of ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured at work while she was lifting on xx-xx-xx. She underwent an ESI with Dr. A repeat lumbar ESI is being requested. The documentation indicates L4/5 and L5/S1 DDD with clinical findings consistent with left L5 radiculopathy in the form of weakness in the left L5 myotome and provocation of sensory symptoms with dural irritation maneuvers.

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

The ODG recommends the following as criteria for ESI:

- 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. Criterion not met
- (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Criterion met.
- (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. Criterion 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. Criterion is not met as per the notes of the V. Viola PA-C, who indicates a left L5 radiculopathy is attributed to a far left L4/5 HNP. This does not make anatomical sense assuming normal anatomy is present. This presentation would lead to a L4 left radiculopathy.
- (5) No more than two nerve root levels should be injected using transforaminal blocks. Criterion is met.
- (6) No more than one interlaminar level should be injected at one session. Criterion is met.
- (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. Criterion is met.

(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. Criterion is met.

(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. Criterion is met.

(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. Criterion is met.

(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.) Criterion is met.

The reviewer indicates that all of the criteria have not been met as described above. Therefore, this procedure 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)