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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 8/13/10

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a diagnostic lumbar epidural block under fluoroscopy.

**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 as well as Pain Management. The reviewer has been practicing for greater than 15 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 diagnostic lumbar epidural block under fluoroscopy.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: Dr. and. These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: undated patient information form, 4/8/10 to 7/22/10 office visit worksheets (WS), 4/8/10 to 6/15/10 re-evaluations by Dr., 3/9/10 history and physical form and report, 3/25/10 pt clinical history and progress notes, undated consult note, handwritten note (undated), 3/9/10 to 7/22/10 problem oriented nurse notes, 3/29/10 post procedure call back note, pre procedure nursing assessment (date is hard to read, possibly 3/25/10), medication log, 3/9/10 through 7/22/10 scripts by Dr., medication management agreement, 3/25/10 operative report, 3/26/08 MRI of the lumbar spine report, 3/9/10 Rx Guardian report, 2/15/10 script from, MD, 8/11/09 to 2/15/10 reports by Dr., undated physician orders, undated standing orders by Dr. and an undated procedure codes sheet.

: All records received were duplicates of those from the requestor.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient has a presumed diagnosis of post-laminectomy syndrome with lower back pain and leg pain bilaterally (left greater than right). He has had a fusion at L5 with a L1 compression fracture. The MRI of 3/26/08 showed an annular tear at L5/S1. The VAS on 3/9/10 was a 6/10. He underwent a lumbar ESI in late March 2010 and reduced his pain level to a 4/10. On 4/8/10 he had only axial pain with no leg complaints.

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

**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 not met. The MRI was done more than 2 years ago. It reveals an annular tear at L5/S1 with previous instrumentation as well as a paracentral protrusion. Leg symptoms are documented and examination reveals a positive SLR suggestive of radicular symptoms but there is no EMG/NCS for review.

(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. (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 criterion is met)

(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 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.

(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. (This 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. (This 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.) (This criterion is met)

Given that all of the criteria are not met. The reviewer feels that the 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)