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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 2/1/2010

**IRO CASE #:**

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

The services under dispute include a Fluoroguide for spine injection (77003), Mod CS by same physician, 5 years+ (99144), Injection foramen epidural L/S (64483) and Injection foramen epidural add-On (64484).

**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 greater than 10 years of experience in this field and performs similar procedures in active practice.

**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 medical necessity of a Fluoroguide for spine injection (77003), Mod CS by same physician, 5 years+ (99144), Injection foramen epidural L/S (64483) and Injection foramen epidural add-On (64484).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

Dr. Mr. and Specialties.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: office notes by Dr. 11/10/09 to 12/18/09 and lumbar CT scan report 11/17/09.

Specialties: denial letter 12/23/09, denial letter 1/6/10, 12/23/09 peer report by MD, 1/6/10 peer report by M., MD, DWC Form 1 10/1/09, notes from Urgent Care 9/22/09 to 10/1/09 and various DWC 73 forms.

Mr. all records received were duplicates of the above records.

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

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

This worker was injured at work while lifting. The injury was to the lumbar spine and varying symptoms of radiation into the lower extremities. The patient was examined by MD. He was treated with medications and was given an in office drug screen. She was also given an ESI at right L4 and left L5. An CT scan on 11/17/09 notes mild acquired spinal stenosis at L3/4 and L4/5, moderate left sided L5/S1 foraminal stenosis and coarsened trabeculae in the right posterior Ilium.

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

The ODG criteria for an ESI are as follows: **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.

(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. (criteria not met)

(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 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.)

The basis for the denial of this service is that there should be clear evidence of a radicular component of the injury and that there was not a significant positive response to the initial injection. Based upon these issues, the service is found to not be 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)