



MedHealth Review, Inc.

661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax 469-286-0735

Notice of Independent Review Decision

DATE OF REVIEW: 12/21/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a lumbar transforaminal ESI.

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

This review was performed by a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This provider performs this service in practice and 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 lumbar transforaminal ESI.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: xxxxx and xxxxxx

These records consist of the following (duplicate records are only listed from one source): Records reviewed from xxxxx: MD MRI report –

7/8/08, MD New Patient Eval – 8/31/09, Procedure Note – 9/14/09 & 12/4/09, Follow-up Notes – 9/28/09-10/6/09.
Records reviewed from xxxxx: xxxxxx Pre-auth request – 10/2/09, Reconsideration Request – 11/2/09.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

On 9/1/2009 Dr. saw the patient for initial evaluation. He reported bilateral lower extremity pain with increasing intensity. On examination, manual muscle strength testing revealed strength grade 4/5 to 4+/5 in all groups tested in the left lower extremity. Left straight leg raising was positive at 30 degrees, with pain radiating to the posterior thigh, anterior thigh, groin, medial leg, lateral leg and posterior calf. his test was positive on the left. There was point tenderness lateral to the anterior superior iliac spine producing concordant, localized pain. The left patellar reflex was decreased compared with the right. Achilles reflexes were symmetrical. Sensation to light touch was decreased on the left in the L2-L3-L4 and L5 dermatomes. Dr. diagnosed 724.2 lumbar strain, 724.4 lumbar radiculopathy, 722.10 lumbar disc displacement without myelopathy, 722.52 degeneration of lumbar intervertebral disc. He proposed lumbar epidural steroid injection, transforaminal on the left at the L4-L5 and at the L5-S1 spinal levels. Dr noted that the patient was having radicular-type pain unresponsive to conventional noninvasive treatments such as physical therapy, rehabilitation and the use of medication for more than four weeks. The goal of the treatment was to minimize the effects of the patient's injury, prevent further disease, maintain or enhance functional level, and allow the patient to perform appropriate rehabilitation, decrease the amount of medication and promote safe return to normal activities as soon as possible. He explained that additional injections may be necessary. He prescribed Flector patch prn, a trial of Lyrica 75 milligrams po twice daily, continuation of Amrix 15 milligrams each evening prn, and prescribed hydrocodone/APAP 10/325: 0.5-1 po three times daily prn. Lumbar epidural steroid injection with epidurogram was done 9/14/2009.

On a follow-up visit 9/28/09 Dr. noted that he reported 50 percent pain relief for about one week. Pain had improved, but was at level 5/10. Self-reported activity tolerance had improved. Physical examination revealed positive left straight leg raising at 30 degrees. Dr. recommended a second lumbar epidural steroid injection, left-sided L4 and L5.

In a telephone note 10/6/2009 Dr. noted that he encouraged active rehabilitation and advised the patient to do home exercises and remain as active as possible. The goal was to have the patient to return to pre-injury status. On 12/4/2009 Dr. performed transforaminal epidural steroid injection to the left L4-L5 and L5-S1 with epidurogram under fluoroscopic guidance.

MRI of the lumbar spine without contrast July 8, 2008 was reported by Dr. to show the following:

- Degenerative disc disease most prominent at L4-L5 with central disc protrusion which is mild with associated annular tear and indentation of the thecal sac, with encroachment upon the right L5 nerve root.
- Postsurgical changes with what appear to be a laminotomy at the L5 level on the right side.
- Findings most consistent with old mild superior endplate compression fracture of L3.
- Normal appearing conus medullaris.

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

This decision must be made on the basis of the submitted records. Epidural steroid injections are a useful treatment for lumbar radiculopathy that has not responded to conservative care. According to the ODG Guidelines, the Procedure Summaries are the most important section of ODG Treatment, and that section (not the Treatment Planning section) should be used as a basis for Utilization Review. The ODG guidelines Procedure Summaries include the following criteria for the use of Epidural steroid injections (ESI): 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.

- Dr. did document that the goal of the treatment was to minimize the effects of the patient's injury, prevent further disease, maintain or enhance functional level, and allow the patient to perform appropriate rehabilitation, decrease the amount of medication and promote safe return to normal activities as soon as possible.

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.

- Dr. documented pain in the distribution of more than one nerve root in the left lower extremity. Muscle strength testing revealed decreased strength on the left side compared with the right, in more than one nerve root distribution. The decreased patellar reflex is consistent with upper lumbar radiculopathy
- The physical examination findings 9/1/09 document positive root tension signs: positive left straight leg raising at 30 degrees, consistent with lower lumbar radiculopathy.

Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

- The submitted records mention medications. The telephone note mentions a recommendation for performing home exercises and remaining active. No records were submitted pertaining to specific physical methods or

actual therapy programs. The submitted records do not document progression to more active treatment programs.

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. Two injections were performed.

Therapeutic phase: If after the initial block/blocks are given and found to produce pain relief of at least 50%-70% pain relief for at least 6-8 weeks, additional blocks may be required. Indications for repeat blocks include acute exacerbation of pain, or new onset of symptoms. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. No records were submitted documenting the amount of pain relief after completion of the initial two blocks. No records were submitted regarding acute exacerbation of pain, new onset of symptoms, continued objective documented pain relief, decreased need for pain medications, ability to participate in rehabilitation, or change in functional status.

The reviewer notes that all of the criteria for this procedure’s approval were not satisfied. Therefore, the procedure cannot be approved at this time based upon the records provided by the parties to the dispute.

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)