



MedHealth Review, Inc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax 972-775-6056

Notice of Independent Review Decision

DATE OF REVIEW: 1/7/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a lumbar epidural injection under fluoroscopy and physical therapy 3x/week for 3 weeks. (62311, 77003, 72275, 99144, 99145, A4550, A4649)

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 epidural injection under fluoroscopy. The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of physical therapy 3x/week for 3 weeks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Dr.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr. 11/9/10 and 12/7/10 office notes by Dr.

11/15/10 denial letter, 12/16/10 denial letter and an undated preauth request form.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

According to available medical records, this individual was injured on xx/xx/xx. There is information in the medical record that she had had two surgical procedures on the lumbar spine although the nature of the procedures was not clarified. There was a statement that a spinal cord stimulator is in place and the stimulator continues to work properly.

A note from December 10, 2009 indicated that this individual was complaining of moderate to severe low back and lower extremity pain and muscle spasms. The note indicated that she had had more than one year of relief from Botox chemo denervation injections. The examiner identified multiple trigger points in the lower back and gluteal muscles as well as limited range of motion of the lumbar spine and recommended repeat Botox injections at that time.

On November 9, 2010, this individual was evaluated by M.D., a pain management specialist. Dr. reported that she was experiencing an exacerbation of low back and lower extremity pain without new accident or injury. He stated that she was performing the home exercise program and using over-the-counter medications, but was not obtaining relief. Dr. documented multiple trigger points in the back and gluteal muscles, greater on the left than the right, decreased sensation to light touch below the knee on the left and limited range of motion of the spine. His assessment was that she was experiencing pain to the back and lower extremities, a myofascial pain syndrome, and an acute exacerbation of symptoms not responsive to conservative care. He recommended a series of two lumbar epidural steroid injections and trigger point injections done two weeks apart. He also recommended Toradol 60mg IM, Celebrex 200 mg b.i.d., Darvocet N100 1 p.o. q8h p.r.n. for pain, and rehabilitation three times a week for three weeks with goals of increasing range of motion, decreasing pain, and allowing the patient to be much more functional.

On November 15, 2010, M.D. reviewed the records and recommended noncertification of the lumbar epidural steroid injections and physical therapy requested by Dr..

On December 7, 2010, Dr. re-evaluated the patient and stated that she was doing well overall until the recent exacerbation of pain previously described. There were no changes in his description of the pain or physical findings. He recommended again a series of two lumbar epidural steroid injections, rehabilitation three times a week, and Ultram 1 p.o. q8h p.r.n.

On December 16, 2010, M.D. reviewed the case and again recommended denial of requested services as not being medically necessary.

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

Available medical records indicate that this individual was injured on xx/xx/xx. She has had extensive treatment of the injury including two lumbar surgeries and placement of a spinal stimulator. According to available medical records, she was doing well until shortly before her evaluation on November 9, 2010 when she began complaining of increased pain in the back and lower extremities. Her examination revealed multiple trigger points in the back and gluteal muscles as well as decreased light touch sensation below the knee on the left and limited range of motion of the lumbar spine.

The treating physician has recommended lumbar steroid injections. ODG Guidelines state that lumbar epidural steroid injections are recommended as a possible option for short-term relief of radicular pain defined as pain in a dermatomal distribution with corroborative findings of radiculopathy. The ODG Guidelines state that a radiculopathy must be documented and objective findings must be present in order to qualify for lumbar epidural steroid injections.

In the available medical records, there is a vague description of lower extremity pain not described as dermatomal. The sensory loss described in the medical record is below the knee, but not described in a dermatomal distribution. There is no description of myotomal weakness, no comment regarding deep tendon reflexes, and no comment regarding sciatic stretch or straight leg raising. There is no accompanying information about electrodiagnostic or imaging abnormalities. Therefore, objective evidence of radiculopathy is not documented in this medical record and ODG Guideline criteria for lumbar epidural steroid injections are not met; therefore the injections are not medically necessary.

The treating physician has further requested physical therapy three times a week for three weeks. The ODG Guidelines recommend physical therapy for strains and sprains of the lumbar or other unspecified areas of the back, ten visits over five to eight weeks allowing for fading treatment frequency from three or more treatments per week to one or less over the five to six week period. Although records do not indicate how much therapy was prescribed or provided throughout the 14 years since the patient's injury, the record does state that the patient was performing a home exercise program with stretching following the onset of this exacerbation and therefore, it is logical to assume that she has been previously instructed in a home exercise program. There is no indication of whether or not she tried heat, ice, or other modalities as part of her conservative care program. Records indicate that her attempts to perform self directed therapy at home did not relieve her symptoms or provide the desired results. Available records indicate that current problems are due to an exacerbation of symptoms caused

by the original injury. Since the patient's attempts to perform her own therapy program were unsuccessful, and the ODG treatment guidelines do recommend physical therapy for management of low back pain, it would seem reasonable and medically necessary for the patient to undergo a course of physical therapy (the requested 9 treatments fall within the recommended 10 treatment sessions) to review, update, and add to her home exercise and treatment program to achieve the goals established and stated by the treating physician.

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)**