



Notice of Independent Review Decision

DATE OF REVIEW: 07/28/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Thoracic Epidural Steroid Injection at T11-T12 with Epidurogram

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

Anesthesiology with Certificate of Added Qualifications in Pain Medicine

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Thoracic Epidural Steroid Injection at T11-T12 with Epidurogram – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Partial Medical Note, M.D., 05/13/11

- Thoracic Spine MRI, M.D., 05/17/11
- Evaluation, Dr. 05/23/11
- Evaluation, M.D., 06/08/11
- Pre-Authorization Request, Dr. 06/09/11, 06/21/11
- Denial Letter, 06/15/11, 06/30/11
- Correspondence, 07/14/11
- The ODG Guidelines were provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The services in dispute include thoracic epidural steroid injection (ESI) at T11-T12, with epidurogram.

This patient was allegedly injured on or about xx/xx/xx when she apparently broke a patient's fall at her place of work where she was employed as. Two days after the injury on xx/xx/xx, the patient presented to Dr. for evaluation, complaining of mid and lower back pain radiating to the left arm and shoulder. He prescribed Hydrocodone, Flexeril, and Naprosyn and referred the patient for a thoracic MRI scan. It demonstrated a central/left disc protrusion at T11-T12 without disc herniation or extruded disc fragment and without neural compression. A central/left T3-T4 disc bulge was also noted, similarly without neural compression.

Dr. re-evaluated the patient on 05/23/11, noting that she had a superior labral anterior posterior (SLAP) tear in her left she and a popping sensation in that shoulder with range of motion. He noted the patient's complaints of midback pain as well as low back pain with shooting pain down both legs, worse on the right. Physical examination documented tenderness of the spinous processes at T3, T4, T10, T11, and T12 as well as of the paraspinal muscles from L2 through L5. Motor examination demonstrated no weakness. Straight leg raising test was said to be positive for radiculopathy in both legs, worse on the right.

Dr. then referred the patient to Dr. for pain management evaluation on 06/08/11. Dr. noted the patient's complaint of left and right midthoracic pain radiating to the left shoulder, mid and upper back, left upper arm, left forearm, bilateral chest, and abdomen. The patient stated her pain level was 9/10 "with pain medication." Dr. noted the patient's medical history of hypertension and heart murmur. He did not make any mention of the thoracic MRI scan or left shoulder imaging study findings. Physical examination documented tenderness over the T3, T4, T11, and T12 spinous processes with "full active range of motion" in all planes of the back. Sensory examination was entirely normal. Reflexes were entirely normal at the knees and ankles. No focal weakness was noted in any muscles. Dr. then recommended the patient have a T11-T12 ESI with epidurogram. He noted the patient's complaint of "insomnia from her Hydrocodone" but then in the next sentence stated the claimant "denies any adverse reactions with current medications."

An initial Physical Adviser Review on 06/15/11 recommended non-authorization of the requested thoracic ESI, noting the MRI scan showed no significant neural compression, and the physical examination showed no significant findings. Citing ODG Guidelines, the adviser stated the request was not medically reasonable or necessary.

A second Physician Adviser reviewed a request for reconsideration on 06/30/11, also recommending non-authorization of the requested procedure based on the lack of nerve root impingement on MRI scan and the lack of documented radiculopathy, motor and sensory deficits, citing ODG Guidelines for thoracic ESI.

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

According to the ODG Guidelines, ESIs are considered medically reasonable and necessary to treat radicular pain consistent with MRI scan findings of disc herniation and nerve root compression when there is concurrent evidence of radiculopathy by either physical examination or electrodiagnostic studies. In this case, the thoracic MRI scan clearly does not demonstrate any evidence of neural compression, and the physical examination clearly does not demonstrate any evidence of radiculopathy. Moreover, according to the ODG Guidelines, ESIs can be considered medically reasonable and necessary after an appropriate course of medication and physical therapy trials, neither of which has been accomplished in this case. Therefore, according to the ODG Treatment Guidelines and nationally accepted standards of medical care, the request for a T11-T12 ESI with epidurogram is not medically reasonable or necessary nor supported by the ODG Treatment Guidelines. The recommendations of the two previous Physician Advisers for non-authorization of the requested procedure are, therefore, upheld.

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)**
- AMA GUIDES 5TH EDITION**