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### **Notice of Independent Review Decision**

**DATE OF REVIEW:** 05/09/2011

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of T9-T10 Thoracic Epidural Steroid Injection, Fluoroscopy, Epidurogram.

**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. This 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 disagrees with the previous adverse determination regarding the T9-T10 Thoracic Epidural Steroid Injection, Fluoroscopy, Epidurogram.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: The Provider, and The Carrier.

These records consist of the following (duplicate records are only listed from one source):  
Records reviewed included:

- 2009/04/01 Electromyography and nerve conduction studies
- 2009/04/10 Cervical Spine X-Rays
- 2009/06/01 Lumbar Spine X-Rays with Flexion and Extension Views
- 2009/08/03 Clinical Records, 2009/08/03
- 2009/11/16 Lumbar Spine X-Rays

- 2010/03/02 Physical Performance Test.
- 2010/03/11 Lumbar Spine X-Rays
- 2010/06/21 Lumbar Spine X-Rays
- 2010/08/20 Rehabilitation Reevaluation
- 2010/08/23 Progress Note from the Chronic Pain Management Program
- 2010/08/26 Report of Medical Evaluation
- 2010/08/30 clinical update, behavioral and mental health, chronic pain management
- 2010/09/22: page 2 of the report from a CT scan
- 2010/10/11 Electrodiagnostic Studies of the Lower Extremities
- 2010/10/11 Electrodiagnostic Studies
- 2011/03/09 History and Physical
- 2011/03/24 Utilization Review Determination of Non-Authorization.
- 2011/04/13 Notification of Adverse Determination after Reconsideration.
- 2011/04/18 Interim History and Physical
- 2011/04/20 Letter Pertaining to the Request for an IRO, Attorney at Law
- 2011/04/20 Request for an IRO

One handwritten prescription from Dr. office for T9-T10 ESI, date not legible, possibly "11/15/10."

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

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

#### **CLINICAL HISTORY:**

Worker was injured at work xx/xx/xxxx. He fell 60 feet and was thrown about while wearing a harness. Records pertaining to the back injuries documented that the injured worker went to surgery August 1, 20XX for right iliac crest bone graft, exploration of the old spinal fusion at L5-S1, laminectomy at L4-L5, and transforaminal lateral interbody fusion at L4-L5. On September 18, 20XX the injured worker went to surgery again for L3-L4 laminectomy, bilateral foraminotomies, posterior spinal fusion at the L3-L4 level, exploration of the previous spinal fusion and removal of hardware.

Electromyography and nerve conduction studies April 1, 20XX were reported to be consistent with a diagnosis of bilateral L5 radiculopathy and nerve root compression on the right L4/L5/S1.

On August 3, 20XX the injured worker saw Dr. for follow-up, complaining of continuing pain in the lower back and some right sided pain. He had a solid C5/6 fusion and a previous anterior lumbar fusion at L4/5, L5/S1. He had physical therapy for several months and epidural steroid injections from Dr.. Neither of these treatments have helped the pain. Diagnostic studies showed L3/4 spinal stenosis adjacent level disease with a 6 millimeter canal. Having failed all non-operative treatments patient was considered to be a surgical candidate. Dr. diagnosed solid L4/5 L5/S1 TLIF with PSF L4-S1, L3/4 spinal stenosis, adjacent level disease with six millimeter spinal canal, and solid C5/6 fusion. He proposed surgery for exploration of the spinal fusion, laminectomy, TLIF L3/4 and PSF L3-L4.

Postoperative lumbar spine x-rays June 21, 2010 were reported to show stable postoperative findings of the lumbar spine

At the follow-up visit June 21, 2010 arrangements were made to refer the injured worker for pain management. On August 30, 2010 Dr. noted that the patient had undergone

work hardening for two weeks but still had pain. Therefore he recommended a CT myelogram to rule out pseudarthrosis of the L3/4 added level. EMG was also requested. CT scan of the spine transcribed September 22, 2010 was reported to show extension of the patient's L4-L5-S1 fusion to include L3-4, left laminotomy, facetectomy, foraminotomy and epidural scarring without stenosis. There was mild disc bulging toward the left foramen and mild left facet joint prominence above the fusion at L2-L3. **"A 1-2 millimeter left paracentral disc protrusion at T9-10 reaches the spinal cord and leaves 8 millimeters residual mid sagittal dural diameter"**.

EMG and nerve conduction studies October 11, 2010 were reported to show (1) chronic right lumbosacral radiculopathy with normal nerve conduction studies and (2) acute on chronic left S1 radiculopathy.

On the follow-up visit November 15, 2010 Dr. noted that **the patient had midthoracic pain and that "he has had this pain all during his time being seen at this office. That is why the CT myelogram included this level". Dr. recommended T9/10 epidural.** On January 3, 2011 Dr. noted that the patient had not yet received his thoracic injections.

Dr. saw the injured worker March 9, 2011 for evaluation of thoracic-related pain. He documented that the patient had thoracic radiating pain at T9-10, radiating into the right and left thoracic just above the umbilicus. Examination of the thoracic spine revealed tenderness over the parathoracic level T9-10/T 10-11. **He planned to perform thoracic epidural targeting the T9- T10 level under fluoroscopy with epidurogram.**

The requested procedures were non-authorized March 24, 2011. The non-authorization was upheld on review April 13, 2011.

Dr. saw the injured worker April 18, 2011, documenting that the patient had a 7/10 pain score. Physical examination revealed radiative pain at the T9-10 dermatomal level on the right and left side to the posterior axillary line. There was right lower extremity pain radiating into the right foot. Dr. planned to submit the CT scan demonstrating the T9-10 defect.

On April 20, 2011 Dr. submitted a request for an independent review. Attorney at Law, P.C. submitted documentation pertaining to the request for an IRO.

#### DIAGNOSTIC STUDIES

- 2009/04/01 Electromyography and nerve conduction studies
- 2009/04/10 cervical spine x-rays
- 2009/06/01 lumbar spine x-rays with flexion and extension views
- 2009/11/16 lumbar spine x-rays
- 2010/03/11 lumbar spine x-rays
- 2010/06/21 lumbar spine x-rays
- 2010/09/22: page 2 of the report from a CT scan, neuroradiologist.
- 2010/10/11 electrodiagnostic studies

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

Based on the records submitted for review, the requested procedure is recommended at this time. The requested procedure meets the ODG Guidelines criteria for procedure 62310 - Diagnostic ESI. The proposed procedure may or may not meet the criteria for procedure 62310 - Therapeutic ESI.

## BASIS FOR THE DECISION

According to the ODG Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic), updated 03/14/11

Procedure code 62310 is defined as Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of **diagnostic or therapeutic** substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic. Pertaining to **Epidural steroid injections, diagnostic**: Recommended as indicated below. (The following criteria have been met)

- 1) To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:
- 2) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies; (this requirement has been met)
- 3) To help to determine pain generators when there is evidence of multi-level nerve root compression;
- 4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive; (this requirement has been met)
- 5) To help to identify the origin of pain in patients who have had previous spinal surgery. (this requirement has been met)

Pertaining to **Epidural steroid injections (ESIs), therapeutic**, Criteria for the use of Epidural steroid injections:

The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use 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. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. (this requirement has been met)
- (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). (this requirement has been met)
- (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.

No more than one interlaminar level should be injected at one session.

**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)