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Notice of Independent Review Decision

DATE OF REVIEW: 11-2-2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a lumbar epidural block under flouroscopy, L4-5 62311 77003.

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 Anesthesiology. 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 lumbar epidural block under flouroscopy, L4-5 62311 77003.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Coventry Health Care.

These records consist of the following:

paperwork
Preauthorization determination 9-15-2011, 8-18-2011
MD prescription and report 8-9-2011
Diagnostic Outpatient Imaging report 1-21-2011
Medical Center report 10-14-2010, 10-18-2010
Functional Capacity Evaluation 4-6-2011
Empi TENS preauthorization 6-2-2011
Physical Therapy report 2-18-2011

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained a work related injury on xx/xx/xx. The patient is now out of work. Examination by an orthopedic surgeon on 08/09/11 showed moderate constant pain with numbness and tingling into the right thigh to foot. Severe back pain with sitting or standing was noted. Normal gait, normal posture, no tenderness to palpation, no pain with extension, flexion, lateral flexion or rotation was also noted.

MRI of the lumbar spine on 01/12/11 showed mild discogenic disease at L4-5, where there is small to moderate sized central disk protrusion which does not cause significant stenosis nor does it appear it to contact any of the exiting nerve roots; remainder of the lumbar spine appears within normal limits.

Current medications are zyrtec, synthroid, lorazepam, Neurontin, Lunesta, Voltaren, tizanidine, and Vicodin.

Other therapies include physical therapy (mentioned in other notes). An FCE on 04/06/11 states that patient is functioning at light PDL. The patient's work requires medium PDL

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 not recommended at this time. The patient's MRI shows mild discogenic disease at L4-L5 with small or moderate sized disk protrusion which does not cause significant canal stenosis nor does it appear to contact any of the exiting nerve roots. However, this MRI does not document correlating concordant nerve root pathology which, per ODG guidelines, must be present to substantiate the procedure. The physical exam does show very definite weakness of the EHL on the right side, but without demonstration of nerve root pathology, the medical necessity of the requested procedure has not been substantiated.

Criteria Used:

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition
Chapter: Low Back- Lumbar and Thoracic

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, 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.
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 the initial use of an ESI (formally referred to 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.
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 percent pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the “therapeutic phase”. Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS,2004)(Boswell, 2007)
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.)

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)