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Notice of Independent Review Decision

DATE OF REVIEW: 11/15/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an Extension Left T11 and L1 Catheter Assisted Transforaminal Epidural Steroid Injection.

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 prospective medical necessity of an Extension Left T11 and L1 Catheter Assisted Transforaminal Epidural Steroid Injection.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: 10/24/11 preauth request, 7/25/11 to 10/3/11 office notes by Dr., 4/21/11 lumbar MRI report and 4/21/11 thoracic MRI report.

FOL: 11/1/11 letter by, ESI language from Low back chapter of ODG, 10/12/11 denial letter, 10/21/11 denial letter, 10/13/11 preauth request, 7/25/11 and 10/6/11 fax confirmation by 10/6/11 preauth request and 7/25/11 preauth request.

A copy of the ODG was provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who sustained an injury to her back on xx/xx/xx while attempting to catch a patient who had passed out. She complains of severe low back pain that radiates to the left anterior thigh. MRI of the thoracic spine on 04/21/2011 revealed T11-12 focal left sided posterior disc protrusion with disc material extending 5mm posterior to vertebral margin that mildly narrows the left side of the thecal sac and left neural foramen with no cord compression. There is disc space narrowing at T7-8, T8-9, and T9-10. MRI of the lumbar spine on the same date revealed L1-2 disc space narrowing and disc desiccation along with minor disc bulging eccentric to left resulting in minimal neural foraminal narrowing on left. The remainder of lumbar spine appears unremarkable.

The patient underwent a left T11 and L1 cath-assisted ESI on 08/01/2011. The claimant was seen in follow up on 10/03/11 and reported about 90% relief for a few days. However, there was no detailed examination of assessment of motor, sensory and reflexes.

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

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition

Chapter: Low Back- Lumbar and Thoracic

Epidural steroid injections, diagnostic

Recommended as indicated below. Diagnostic epidural steroid transforaminal injections are also referred to as selective nerve root blocks, and they were originally developed as a diagnostic technique to determine the level of radicular pain. In studies evaluating the predictive value of selective nerve root blocks, only 5 percent of appropriate patients did not receive relief of pain with injections. No more than 2 levels of blocks should be performed on one day. The response to the local anesthetic is considered an important finding in determining nerve root pathology. When used as a diagnostic technique a small volume of local is used (Epidural steroid injections (ESIs), therapeutic

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. Imaging studies and/or electrodiagnostic testing must corroborate radiculopathy.
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.
8. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

Per ODG, repeat injections should be based on continued objective documented pain relief, decreased need for pain medications and functional response, with at least 50-70% pain relief for 6-8 weeks. Given the limited duration of benefit from the previous injection, the proposed repeat injection is not recommended as medically necessary at this time based upon the records provided and the above criteria.

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)