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## Notice of Independent Review Decision

**DATE OF REVIEW:** 10/17/11

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of 64483, injection, transforaminal epidural, lumbar/sacral and 72275 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. 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 disagrees with the previous adverse determination regarding the prospective medical necessity of 64483, injection, transforaminal epidural, lumbar/sacral and 72275 Epidurogram.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

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

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr. 9/27/11 preauth request, 9/1/11 office notes by Dr. 3/11/11 report by Rehab and Sports Med, 2/8/11 to 3/10/11 notes by Rehab and Sports Med, 2/17/11 lumbar MRI report, 2/2/11 lumbar radiographic report and 7/21/11 report by DO.

IMO: 9/23/11 denial letter and 9/8/11 denial letter.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work related injury to the lower back xx/xx/xx. No records from the initial medical evaluation were submitted. The radiology report on the day of the injury lists as the reason for the exam "fell today landing on his back". X-rays of the lumbosacral spine 2/22/2011 were reported to show mild levoscoliosis of the mid lumbar spine, no evidence for fractures or dislocations, and mild spondylosis.

MRI of the lumbar spine 2/17/2011, was reported to show "degenerative change in the lumbar spine yet no high-grade central canal or foraminal narrowing is seen". L1-L2 shows no significant disease, L2-L3 shows a concentric disc bulge with facet and ligament hypertrophy producing no significant central canal or foraminal narrowing. L3-L4 shows a concentric disc bulge with facet and ligament hypertrophy producing mild central canal and bilateral neural foraminal narrowing. L4-L5 shows a concentric disc bulge with facet and ligament hypertrophy producing mild right and moderate left neural foraminal narrowing. No significant central canal narrowing is seen. L5-S I shows a concentric disc bulge with facet and ligament hypertrophy however no significant central canal or foraminal narrowing is seen. Incidental note is made of signal alteration in the left kidney which may represent peripelvic cyst or hydronephrosis.

The injured worker received seven physical therapy sessions with good results. According to the summary which was submitted 3/11/2011 after completion of the therapy program, the VAS pain level had improved from 5/10 to 1/10. After completing therapy, there was no complaint of pain in the right lower extremity, the Oswestry score was 20%, and the worker was released to full activity. Continuation of the home exercise program was recommended.

On the outpatient follow-up visit 7/21/2011 the worker reported to Dr. that he was working nights and was continuing the home exercise program. Leg numbness and pain were "much improved" but back pain affected daily activities. The worker walked with an antalgic gait. Straight leg raising (sitting/distracted) was positive on the right.

On 09/01/2011 the worker was seen in consultation by Bolkar Sahinler, M.D. for evaluation and treatment. The VAS pain level was 5. A Medrol Dosepak had not given long-lasting relief. Physical examination revealed pain to palpation over lumbar facet joints with no palpable muscle spasm. Lumbar range of motion was restricted. There was positive bilateral straight leg raise for back pain and radiculopathy, positive bilateral slump for back pain and radiculopathy, and positive bilateral Kemp. Dr. diagnosed bulging lumbar disc with lumbosacral radiculopathy and recommended bilateral L4 transforaminal epidural steroid injection with epidurogram. The worker was encouraged to keep an active lifestyle, to maintain a mild exercise routine, and was advised against bed rest for more than four days.

The requested procedures were non-authorized 9/8/2011. The adverse determination was upheld 9/23/2011.

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

After the injury the worker was treated promptly with medications and with a course of physical therapy, with good results. He was continuing a home exercise program at the time of the outpatient visit 7/21/2011, when he reported that he was working and was continuing the home exercise program, but pain affected daily activities. Straight leg raising (sitting/distracted) was positive on the right. On Dr. examination 9/01/2011 the physical findings were consistent with a clinical diagnosis of lumbar

radiculitis/radiculopathy. Furthermore, The MRI 2/17/2011 had shown at the L4-L5 level a concentric disc bulge with facet and ligament hypertrophy producing mild right and moderate left neural foraminal narrowing. Although the findings on the MRI do not specifically demonstrate a lumbar nerve root compression injury, the findings do corroborate the clinical findings reported on Dr. physical examination 7 months post MRI.

According to the ODG Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic), updated 09/21/11:

- ESIs may be helpful with radicular symptoms not responsive to 2 to 6 weeks of conservative therapy. Epidural steroid injections are an option for short-term pain relief of persistent radiculopathy, although not for nonspecific low back pain or spinal stenosis.
- ESIs are more often successful in patients without significant compression of the nerve root and, therefore, in whom an inflammatory basis for radicular pain is most likely. In such patients, a success rate of 75% renders ESI an attractive temporary alternative to surgery, but in patients with significant compression of the nerve root, the likelihood of benefiting from ESI is low (26%).
- 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.
- Criteria for the use of Epidural steroid injections:
  - o Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
  - o Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
  - o Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
  - o 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.
  - o No more than two nerve root levels should be injected using transforaminal blocks.
  - o No more than one interlaminar level should be injected at one session.
  - o 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% 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.

- o Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.
- o 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.
- o 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.
- o 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.)

The records indicate that the injured worker meets the criteria listed above for the requested procedure. The reviewer indicates that this patient has performed 7 of the 10 allowed ODG scripted sessions for PT and is performing a home exercise protocol as per guidelines. However, the injured worker is still experiencing pain and reduced ADL's. The ODG states “Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program.” The requested procedure fits within the recommended procedures of the ODG that states “As noted above, injections are recommended if they can facilitate a return to functionality (via activity & exercise).” Due to the above factors, the requested procedure is found to be medically necessary at this time.

**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)