

**MRI**

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**Notice of Independent Review Decision**

**DATE OF REVIEW** 8/26/11

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of lumbar epidural steroid injections L4/5 with anesthesia (62311, 36000, 72100, 76000, Q9966, 00630)

**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 lumbar epidural steroid injections L4/5 with anesthesia (62311, 36000, 72100, 76000, Q9966, 00630)

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured when she fell on xx/xx/xxxx. She has been managed with TCA, narcotics and NSAID's. A herniated nucleus pulposus was verified by MRI at L4/5. An EMG/NCS report offered a questionable interpretation of peroneal neuropathy bilaterally. A L5/S1 ESI was performed on 10/27/10 yielding minimal relief. An ESI at L4/5 is proposed as a diagnostic maneuver per Dr. letter on 7/15/11.

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

The reviewer notes that a L4/5 ESI is recommended as a diagnostic maneuver instead of a second injection at the original L5/S1 site. There is evidence of a L4/5 HNP and EMG suggests possible L4 or L5 radiculopathy based upon the report provided in the records.

The criteria for an ESI are as follows: 1) To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below: (the reviewer indicates that the patient had a verified sacral fracture)

2) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies; (This goal was verified by Dr. on 7/15/11)

3) To help to determine pain generators when there is evidence of multi-level nerve root compression; (The sacral fractures could have produced sacral radiculopathy as well)

4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive; (This criterion is met per the reviewer)

5) To help to identify the origin of pain in patients who have had previous spinal surgery. (not applicable)

According to the reviewer, the medical records provided document the medical necessity for the requested procedure. Therefore, the service 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)**