



MedHealth Review, Inc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax 972-775-6056

Notice of Independent Review Decision

DATE OF REVIEW: 1/20/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a lumbar selective nerve root block/Transforaminal Epidural Steroid Injection on the left at L3, L4 and L5 (64483 and 64484).

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 5 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 a lumbar selective nerve root block/Transforaminal Epidural Steroid Injection on the left at L3, L4 and L5 (64483 and 64484).

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: 10/25/11 denial letter, undated report by MD, 10/20/11 precert request by Dr., 10/18/11 to 11/13/11 office notes by Dr., 6/3/11 operative report, 1/24/11 operative report, 11/18/11 denial letter, 11/16/11 report by MD, and 11/14/11 precert request by Dr..

Dr.: office notes by Dr. from 4/9/09 to 8/6/09, 5/21/09 lumbar CT scan report and an operative report of 7/24/09 and 11/18/09.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. Per clinical note dated 01/24/2011, the patient underwent an S1 nerve root epidurogram and right S1 TFESI under fluoroscopic guidance and left L3-L4 TFESI under fluoroscopic guidance. Per note dated 06/03/2011, the patient underwent a left L3, L4 and S1 TFESI. Per note dated 10/18/2011, patient had been experiencing left lower extremity symptoms for two weeks. The symptoms are described as intermittent, tingling and pins and needles of varying intensity. Patient's symptoms are made better by nothing and have been gradually worsening since onset. Patient's pain is located in the anterior thigh and hip and is a 7/10. Patient reports complete pain relief from the L3, L4 and S1 TFESI and had a positive steroid response with 60-65% relief that lasted 3 months. Physical examination reveals decreased pinprick sensation at S1. Patient's motor exam was normal except 4/5 strength at left quadriceps and fibula. Patient's straight leg raise demonstrated bilateral radiating leg pain.

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

Epidural steroid injections, diagnostic are 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. 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 on 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

This claimant was injured on xx/xx/xx and underwent an S1 transforaminal epidural steroid injection under fluoroscopic guidance and a left L3-L4 transforaminal epidural steroid injection under fluoroscopic guidance on 01/24/2011, and underwent an L3, L4 and S1 spinal nerve with transforaminal epidural steroid injection on 06/03/2011. The patient described left lower extremity symptoms as tingling and pins and needles. The notes report that the patient had 60-65% relief of symptoms for 3 months. Official Disability Guidelines recommend that repeat injections when the patient was found to produce pain relief of at least 50-70% for 6-8 with decreased need for pain medication and functional response. According to the clinical documentation provided, there is lack of evidence that the patient had a decreased need for pain medications and that the patient had functional improvement. Therefore, this request is found to be not 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)