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## Notice of Independent Review Decision

**DATE NOTICE SENT TO ALL PARTIES:** 9/10/12

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

The item in dispute is the prospective medical necessity of an outpatient left lumbar L4/5 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 Orthopedic Surgery. 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 outpatient left lumbar L4/5 transforaminal epidural steroid injection.

### **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.: 7/3/12 patient eval by Dr..

: 8/24/12 prospective review response, 8/7/12 denial letter, 6/20/12 and 8/1/12 reports by DO, 8/1/12 preauth request, 8/1/12 substantial change assessment, 8/23/12 denial letter, 8/20/12 report by MD, 8/20/12 DARTS screen print, 6/20/12 preauth request, 5/25/12 lumbar MRI report, progress notes by MD from 6/15/12, 7/30/12 referral from Dr. to Dr., and 7/20/12 report by MD.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:** On the injury date, the claimant was bent over digging dirt with a shovel and felt back pain. Since that time, he

has experienced back pain with radiation into the thighs. He has been treated with medications, PT, chiropractic and epidural steroid injections (ESIs). The most recent lumbar MRI dated 5/25/12 revealed degenerative changes including disc bulges and mild foraminal narrowing. AP records were reviewed, including from 7/3/12 in which the neurologic examination was normal. A 7/5/12 dated electrical study of the lower extremities noted peripheral neuropathy and a left L5 radiculopathy. Denial letters evidenced the lack of objective evidence of radiculopathy and the most recent MRI having not revealed significant nerve root impingement due to disc herniation. In addition, the letters noted the lack of documentation of a 50% plus reduction in pain for a 6-8 week period from prior ESIs.

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

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 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.

(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% 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.

(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.)

Without any recent abnormalities of sensation, reflexes and/or lower extremity motor power; objective evidence of radiculopathy has not been documented. In addition, guideline-associated criteria (at least 50 % reduction of pain for 6-8 weeks) for repeat ESIs have not been evidenced from the prior ESIs. Therefore, ODG criteria for the request have not been met at this time and the requested procedure 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)