



# MedHealth Review, Inc.

661 E. Main Street  
Suite 200-305  
Midlothian, TX 76065  
Ph 972-921-9094  
Fax (972) 827-3707

## Notice of Independent Review Decision

**DATE NOTICE SENT TO ALL PARTIES:** 6/30/14

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of right L4 and L5 transforaminal ESI.

### **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 agrees with the previous adverse determination regarding the prospective medical necessity of right L4 and L5 transforaminal ESI.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

He has a history of right hip pain with a history of right hip surgery. He reported a back injury xx/xx/xx. He had an MRI that shows right sided disc herniation L4/5 and L5/S1. He has positive straight leg raise on right. He has decreased right

sided reflexes and decreased right L4/5 sensation. MRI of the hips does show irregularity of the labrum. He has had physical therapy with minimal change in pain.

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

This claimant does have back pain with radicular findings. He has not improved with physical therapy. The ODG does support the use of ESI to decrease pain so that activity can increase in an exercise program and in lieu of surgery. The request does not meet ODG guidelines (specifically, the neurodiagnostic confirmation section) as found in the chronic pain chapter of the ODG.

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, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

- 1) Radiculopathy must be documented by physical examination and 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) for guidance.
- 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)
- 8) Current research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.

9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block.

**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)