

Notice of Independent Review Decision
REVISED DECISION
 See bold print

REVIEWER'S REPORT

DATE OF REVIEW: 04/04/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Lumbar epidural steroid injection with fluoroscopy, left L5/S1.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.O., duly licensed in the State of Texas, Fellowship Trained in Pain Medicine, ABA, Board Certified in Anesthesiology with Certificate of Added Qualifications in Pain Medicine, with over twenty years of clinical experience in the active practice of Pain Management

REVIEW OUTCOME:

"Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
722.10		NA	Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:

- TDI case assignment.
- Letters of denial and denial criteria (ODG 03/03/08 & 03/14/08).
- Neurosurgeon's progress documentation 09/11/03 – 03/05/08.
- Operative reports, radiology reports and discharge summaries 02/25/04 – 12/05/07.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

According to the medical records, this claimant was injured on xx/xx/xx while lifting a lead shield. He was initially evaluated on 09/11/03 complaining only of neck and intrascapular pain radiating to both shoulders and arms. There was no mention of any lumbar or lower extremities complaints nor any examination of those areas. Anterior cervical discectomy and fusion at the C6/C7 level was performed on 02/25/04. **It should be noted that the TDI IRO Assignment indicates a**

second injury date of xx/xx/xx; however, little or no records or documentation were seen relating to this injury

It was not until 09/16/04, **fourteen months following the xx/xx injury, and, apparently, seven months following the xx/injury**, that any mention was made of this claimant's having lumbar and left leg pain. No examination of the claimant's lumbar spine was documented until November 2004 when mention is made only of the claimant's having a decreased lumbar lordosis. On 12/01/04 the treating doctor then performed the first of four lumbar myelograms. It demonstrated "no significant lateralizing defect and no stenosis." Post myelogram CT scan demonstrated minimal to mild disc bulges at L2/L3, L3/L4, L4/L5, and L5/S1 with no significant canal or foraminal stenosis and no spinal cord or nerve root compression.

The treating doctor then performed the first of eleven epidural steroid injections on this claimant on 12/21/04. He followed up with the claimant on 01/06/05, noting the claimant's increasing pain, which he stated was "all due to his lumbar disc disease." On 02/14/05 the TD reiterated that the claimant did not get long-lasting relief from epidural steroid injection.

A second lumbar myelogram was performed on 06/22/05, again demonstrating "no significant central or lateralizing defect in the lumbar region," stating that this study was considered "within the limits of normal." Post myelogram CT scan again demonstrated minimal disc bulges at L2/L3 and L3/L4 with no foraminal or canal stenosis, mild disc bulge at L4/L5, and no abnormalities at L5/S1. Re-do C6/C7 fusion as well as takedown and refusion at the C5/C6 level was performed on 08/23/05.

Follow up with the claimant on 11/07/05 noted that previous myelograms "did not show any definite stenosis or root compression." Despite the clear absence of any benefit from the two prior lumbar epidural steroid injections, as well as the clear absence of any pathology on the myelogram to justify them, the TD then embarked on more lumbar epidural steroid injections on 11/29/05. Five weeks later, the claimant's pain was documented as having increased over the past several weeks, indicating that the lumbar epidural steroid injection provided no more than a couple of weeks of relief. Another lumbar epidural steroid injection was performed on 03/07/06, with follow up approximately three months later, again documenting the same increasing lumbar and bilateral pain.

A third lumbar myelogram was then performed on 06/28/06, again demonstrating "no major central or lateralizing defects." The myelogram also showed "no central stenosis or nerve root sheath amputation." Post myelogram CT scan demonstrated no significant bulges at T12/L1 or L1/L2, minimal disc bulges with no stenosis or nerve root compromise at L2/L3, L3/L4, and L4/L5, and a broad-based left disc protrusion at L5/S1. Given the myelogram evidence of no nerve root sheath amputation and no filling defects, none of these findings are of any significance.

A fourth lumbar epidural steroid injection was performed on 08/09/06 with follow up five days later documenting continued left leg pain. A fifth epidural steroid injection, this time in the neck, was performed on 08/30/06. Five weeks later the TD documented the claimant's increasing lumbar and left leg pain. On 11/15/06 he performed a sixth lumbar epidural steroid injection, the third in this series of three. On 01/03/07 another cervical epidural steroid injection was performed, the fourth epidural steroid injection in all over the previous five months and the seventh since this began.

A fourth lumbar myelogram was then performed on 03/27/07, again demonstrating "no significant central or lateralizing defects" and "no significant" narrowing "of the contrast column to indicate a

significant component of central spinal stenosis.” Post myelogram CT scan again demonstrated clinically insignificant mild disc bulges at L2/L3, L3/L4, and L4/L5 with no focal disc protrusion, no spinal cord compression, and no nerve root compromise. A left disc bulge was seen at L5/S1 but again without any focal protrusion or focal nerve root compromise.

A cervical epidural steroid injection was then performed on 04/17/07 followed by a lumbar epidural steroid injection on 05/09/07, then ninth such injection since 11/29/05 and the eleventh such injection since treatment began. On 08/20/07 the claimant returned, still complaining of the same lumbar and bilateral hip pain.

A tenth epidural steroid injection, this time in the neck, was performed on 09/04/07. This now made twelve epidural steroid injections, combining both cervical and lumbar. On 11/19/07 it was noted that the claimant “has made no improvement” despite all the epidural steroid injections. An eleventh epidural steroid injection, this one in the lumbar spine, was performed on 12/05/07. Documentation on 02/25/08 noted the patient’s “increasing pain.”

A total of thirteen epidural steroid injections have been performed on this claimant’s cervical and lumbar spine. Two separate physician reviewers have reviewed the request for another lumbar epidural steroid injection on 03/03/08 and 03/14/08. Both reviewers independently recommended non-authorization, citing lack of support in nationally-accepted guidelines. The second reviewer, a neurosurgeon, documented that there was “no clear documentation of at least 50% to 70% pain relief for six to eight weeks from the previous injection.”

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

Lumbar epidural steroid injections are indicated for the treatment of clinically proven radiculopathy due to lumbar disc herniation causing either spinal stenosis or foraminal nerve root compression. In this case, there is clearly no evidence of any electrodiagnostic study ever being done to document radiculopathy. Furthermore and more importantly, there has been no evidence on any of four lumbar myelograms and CT scans performed on this claimant of any significant pathology, focal disc herniation, spinal or foraminal stenosis, and especially, nerve root compression.

This claimant has never had any significant sustained relief of pain from any of the numerous epidural steroid injections performed. Clearly, neither ODG Guidelines or ACOEM Treatment Guidelines provide any support for any further such injections.

Therefore, absent any electrodiagnostic evidence of radiculopathy, any radiologic imaging study evidence of focal disc herniation producing either spinal cord or nerve root compromise, and any clinical evidence of this claimant getting significant and sustained benefit from any of the multiple lumbar epidural steroid injections performed by Dr. over the last few years, there is absolutely no medical reason, necessity, indication, or justification for any further lumbar epidural steroid injections. Therefore, the previous recommendations for non-authorization of the requested lumbar epidural steroid injections with fluoroscopy at left L5/S1 is upheld.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

INDEPENDENT REVIEW INCORPORATED

- 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 national accepted medical literature (provide a description).
 - Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)
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