

SENT VIA EMAIL OR FAX ON  
Dec/15/2010

## Applied Assessments LLC

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**  
Dec/15/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Lumbar Caudal Epidural Steroid Injection with Catheter under Fluoroscopy and with IV Sedation

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management  
Subspecialty Board Certified in Electrodiagnostic Medicine  
Residency Training PMR and ORTHOPAEDIC SURGERY

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines  
Denial Letters 11/10/10 and 9/21/10  
Dr. 3/25/10 thru 11/22/10  
MRI 3/4/09  
Dr. 3/16/09  
12/3/10  
Minimally Invasive Spine 8/11/10  
Progress Notes 6/17/10 thru 7/8/10  
Radiology Reports 5/13/10, 4/19/10, 5/6/10, 3/4/09  
Dr. 7/30/09 thru 12/17/09

## **PATIENT CLINICAL HISTORY SUMMARY**

This is a man reportedly injured on xx/xx/xx. He had low back pain. An MRI done on 3/14/09 showed bilateral neural foraminal narrowing at L5 with an L5/S1 disc protrusion. He reportedly had an EMG done on 3/16/0-9. Dr. described it "the patient has findings of bilateral L5 radiculopathies that have no associated active denervation. There is mild involvement on the right at S1." He had his first lumbar ESI on 8/20/09. The 9/4/09 note described some relief, but he had a second ESI on 9/17/09. Dr. noted on 10/2 of only a week of relief with the injection. He had a third ESI on 12/17/09 at L4/5 by Dr.. There is no report from Dr. of any post procedure relief. It presumably did not help and Dr. referred him to Dr.. The only examination sent by Dr. was on 3/25/10. He described local tenderness and reduced lumbar motion and positive SLR. He wrote, "Pinprick sensation was diminished in a non-segmental, dermatomal fashion on the left." He found symmetrical knee and ankle jerks at 1+. A CT Myelogram on 5/13/10 showed abutment of the S1 roots, and possibly L5 root compromise. There is a 6/17/10 examination by Dr. where he noted normal sensation and reflexes. There is an unsigned record from the dated 8/11/10. The examiner described problems with heel walking on the left. "Otherwise all major muscle groups of the bilateral lower extremities ...full strength. Sensation is diminished along "lateral calf and leg. He/she also noted a reduced left ankle jerk compared to the right. The examiner suggested a lumbar fusion.

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

The letters from Dr. suggest this is for a therapeutic radiculopathy. The radiological studies show the degenerative changes in the spine with probable nerve root compromise. The EMG reportedly showed a radiculopathy, but there was no denervation changes. The EMG was a month post injury, and denervation changes are likely. No specific changes were described. So, this man did not meet the AMA (or ODG) electrodiagnostic criteria for a radiculopathy.

### **"Electrodiagnostic verification of Radiculopathy.**

Unequivocal electrodiagnostic evidence of acute nerve root pathology includes the presence of multiple positive sharp waves or fibrillation potentials in muscles innervated by one nerve root. However the quality of the person performing and interpreting the study is critical. Electromyography should be performed only by a licensed physician qualified by reason of education, training and experience in these procedures. Electromyography does not detect all compressive radiculopathies and cannot determine the cause of the nerve root pathology. On the other hand, electromyography can detect noncompressive radiculopathies, which are not identified by imaging studies. "

Page 382-382. AMA Guides to the Evaluation of Permanent Impairment. 5th edition

Next is the need for documented abnormal neurological examination. This includes weakness, abnormal reflexes and abnormal sensation in a dermatomal distribution or any atrophy. Dr. found a normal neurological exam, as did Dr.. The neurosurgeon did not.

Based upon these findings and descriptions, the diagnosis of a radiculopathy has not been fully established along the AMA Guides criteria.

However, we can still consider that he had a radiculopathy confirmed and therefore had the prior 3 ESIs.

The ODG does accept up to 4 repeat ESIs in a year provided there is pain relief of at least 50-70% lasting 4-6 weeks. He had the first injection followed by a second in 2 weeks. He only had a week of relief from this combined procedure. This should have excluded the third injection. He did have the third on December 17, 2009. There is no follow up note describing the relief. Presumably, he did not get much relief, or he would not have seen Dr. 14 weeks later. It is possible that he had 6 weeks of relief, but nothing was provided to confirm that.

Again, since he had to see Dr., the IRO reviewer presumes that he did not have the lasting relief required by the ODG for repeating the procedures. From the information provided, the request is not medically necessary.

**Epidural steroid injections (ESIs), therapeutic**  
**Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. See specific criteria for use below.** Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition.....

**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. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. ([Andersson, 2000](#)) Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.**

**(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. ([CMS, 2004](#)) ([Boswell, 2007](#))**

## **“Radiculopathy**

**Radiculopathy for the purposes of the Guides is defined as significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots. The diagnosis requires a dermatomal distribution of pain, numbness, and/or paresthesias in a dermatomal distribution. The diagnosis of herniated disc must be substantiated by an appropriate finding on the imaging study. The presence of findings on a imaging study in and of itself does not make the diagnosis of radiculopathy. There must also be evidence as described above. “**

## **“Atrophy**

**Atrophy is measured with a tape measure at identical levels on both limbs. For reasons or reproducibility, the difference in circumference should be 2cm or greater in the thigh and 1cm or greater in the arm, forearm, or leg...”**

## **“Electrodiagnostic verification of Radiculopathy.**

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**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)