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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 2, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Injection, Anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level

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

This reviewer is a Physical Medicine and Rehabilitation Physician with 14 years of experience.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On xx/xx/xx, the claimant participated in a physical therapy sessions. He had complaints of pain at the left lower back into buttocks with tingling into toes and now progressing into entire plantar foot and heel. He stands with decreased weight bearing on the left and walks with right toe out. Impression: Lumbosacral sprain.

On May 19, 2010, an MRI of the lumbar spine was performed. Impression: 1. Diagnostic degenerative arthrosis at levels between L3 and S1. 2. Neural foraminal narrowing is bilaterally severe at L4-L5, and worse on the left. 3. Neural foraminal narrowing is bilaterally moderate at L5-S1. 4. Neural foraminal narrowing is bilaterally moderate at L3-L4. 5. Narrow L5 vertebral body with grade 1 anterolisthesis of the posterior L5 margin. 6. Possible L5 spondylolysis. Oblique radiographs or CT may be informative. 7. Nodular soft tissue along anterior liver. Differential includes interposed normal bowel, liver cyst, lymph node, and neoplasm. Ultrasound is recommended as interpreted by M.D.

On May 19, 2010, the claimant attended a second physical therapy session. He still complains of pain down into his leg with symptoms still worse with extension and lateral flexion towards left side.

On May 20, 2010, the claimant attended a second physical therapy session. He is mildly better at most, he still has symptoms down left leg, mostly tingling.

On July 1, 2010, the claimant was evaluated by M.D., a physical medicine and rehabilitation physician. He reported tingling of all left toes. He described his pain as aching, shooting, throbbing, and sharp. He is currently taking Celebrex 200 mg daily and Skelaxin 800 mg 3 times a day for adequate pain relief. In addition he is using a TENS unit with good relief. He reports no pain relief with physical therapy. He has no tenderness to the lumbar spine, moderate tenderness to palpation over the left lower lumbar paravertebral muscles. Straight leg raise supine and sitting reproduces pain in the left calf. Impression: Lumbar back pain and left lower extremity pain consistent with lumbar radiculopathy. He will try a Medrol Dosepak and discontinue Celebrex.

On July 8, 2010, the claimant was re-evaluated by, M.D. He completed the Medrol Dosepak and noted that his pain decreased until last night following a day of mowing the grass. He was unable to sleep due to the pain. Recommendations: As the claimant received significant pain relief with the Medrol Dosepak, he would likely benefit from a lumbar epidural steroid injection.

On July 29, 2010, the claimant was re-evaluated by M.D. He still complains of tingling in his left toes with associated numbness. His pain is worse after walking for extended periods of time. His TENS unit and ice help alleviate the pain. He did not receive any pain relief with physical therapy.

On August 12, 2010, an EMG of the lower extremities was performed. Impression: 1. Left sural sensory nerve conduction study was normal. 2. Left peroneal motor and nerve conduction study to the EDB muscle was normal. 3. Needle electromyography of selected left lower extremity and left lumbar paravertebral muscle was normal as interpreted by M.D.

On October 1, 2010, the claimant was evaluated by D.O., a neurosurgeon. He currently rates his pain a 7 out of 10 on the VAS scale. He complains of weakness, numbness and tingling in the left foot. Diagnostic Studies: MRI of the lumbar spine from May 2010 demonstrates at L4-5 disc bulge, which severely narrows the neural foramen, worse on the left. Disc bulge does appear to contact the exiting nerve roots. AP canal diameter is approximately 12 mm. There appears to be possible L5 pars defects bilaterally. At L5-S1, there is a grade 1 anterolisthesis and neural foramen appeared to be narrowed bilaterally. Impression: Low back pain with intermittent left leg pain. Dr. recommended a lumbar epidural steroid injection.

On October 6, 2010, x-rays of the lumbar spine were performed. Impression: 1. Grade 1 anterolisthesis of L5 relative to S1. No evidence for instability at this level. 2. Disc space narrowing at the L4-5 and L5-S1 levels as interpreted by M.D.

On October 12, 2010, the claimant was evaluated by M.D., a physical medicine and rehabilitation physician. His pain level is a 7 out of 10 of the VAS scale. He has aching, stabbing, shooting, tightness and sharp pain with some associated weakness. Forward flexion reproduces left leg pain. There is positive straight leg raise at 30 degrees both supine and seated position on the left. Cross straight leg raise is negative to 90 degrees on the right in both supine and seated positions. Dr. recommended a lumbar epidural steroid injection.

On October 25, 2010, a occupational medicine physician, performed a utilization review on the claimant. Rationale: The history and documentation do no objectively support the request for an ESI for this patient who has pain radiating down his leg but no evidence of radiculopathy of physical examination or by electrodiagnostic studies. The medical necessity of an ESI has not been clearly demonstrated based on this history provided for review. Therefore, it is not certified.

On November 17, 2010, , a physical medicine and rehabilitation physician, performed a utilization review on the claimant. Rationale: The documentation submitted elaborates the patient complaining of low back pain that he rated as 7/10. The patient needs to have been unresponsive to conservative treatment to include physical medicine as well as a pharmacological intervention. The documentation does not elaborate into the patient's radiculopathy confirmed by electrodiagnostic testing. Therefore, it is not certified.

PATIENT CLINICAL HISTORY:

On xx/xx/xx, the claimant sustained an injury to the lumbar spine when he was and hurt his lower back on the left side.

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

The previous decisions are overturned based on the submitted documents which indicate that the claimant has radicular symptoms. Radiculopathy is documented by objective finding on exam; provocative testing with seated and supine left SLR which reproduces left lower extremity pain on Dr. exam on 7/1/10 and Dr. exam on 10/12/10. Which is corroborated by imaging study read by Dr. on 10/1/10 (Dr. MRI reading: "Demonstrates at L4-5 disc bulge, which severely narrows the neural foramen, worse on the left. Disc bulge does appear to contact the exiting nerve roots."). Furthermore, the claimant has been unresponsive to conservative care including medicines (Celebrex and Skelaxin) and physical therapy (noted on Dr. evals in July 2010).

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.
(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. (CMS, 2004) (Boswell, 2007)
(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.)

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)**