

I-Decisions Inc.

An Independent Review Organization

5501 A Balcones Drive, #264

Austin, TX 78731

Phone: (512) 394-8504

Fax: (207) 470-1032

Email: manager@i-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/01/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Nerve Block/Transforaminal Epidural Steroid Injection at the Right L3 Level Under Fluoroscopy

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

M.D., Board Certified Orthopedic Surgeon

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

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter lumbar, epidural steroid injection

Adverse Determination Letters, ESIS, 1/4/10, 12/11/09

Office note Dr. 10/26/05

Office note Dr. 01/18/06, 05/16/09, 07/25/06, 10/10/06, 12/12/06, 04/27/07, 06/04/07, 10/24/07, 01/29/08, 04/10/09

Office note, PA-C 05/01/06, 06/15/06, 05/08/07, 05/17/07, 06/18/07, 07/25/07, 08/14/07, 11/27/07, 07/29/08

Pre-Surgical evaluation Dr. 01/30/07

Operative report Dr. 02/26/07

Office note, PA-C 07/10/08, 06/29/09, 08/07/09

Operative report Dr. 08/22/08, 09/03/08

Office note, PA-C 09/17/08, 11/11/08

Physical therapy notes 03/27/09 to 05/21/09

IME Dr. 06/04/09

MRI lumbar spine 07/30/09

Office note Dr. 08/07/09

Office note Dr. 09/23/09, 10/12/09, 11/11/09, 11/24/09, 12/03/09, 12/22/09

Lumbar spine x-rays 11/19/09

CT lumbar spine 11/13/09

Office note Dr. 11/30/09

Office note Dr. 12/11/09

Office note Dr. 01/04/10

PATIENT CLINICAL HISTORY SUMMARY

This male is status post multiple back surgeries. The most recent L2-5 fusion was in 11/2008 and then 02/12/09 hardware removal due to a protruding screw at L4 on the left. The 07/30/09 MRI of the lumbar spine showed interval decompression at L2-3 levels since the most recent prior study with satisfactory appearance of the spinal canal at this level. Prior lumbar lesions at L3-4 and L4-5 are noted. On 09/23/09, Dr. evaluated the claimant for back and right leg numbness. Root tension on the right caused buttock pain only. Dr. reviewed the 03/07/08 CT myelogram and the 07/30/09 MRI. Diagnosis was episodic bowel and bladder incontinence, possible pseudoarthrosis L2 to L4, mechanical back pain and sciatica type symptoms. Dr. noted that arachnoiditis may be the best explanation and that the CT myelogram was not sufficient to show bone detail. The CT scan of the lumbar spine from 11/13/09 showed newly detected loosening of the right posterior L3 screw at the pedicle and lateral mass. Right foraminal stenosis at L2-3 was caused by development of degenerative osteophyte from the L3 superior articular process. The 11/19/09 lumbar spine x-rays showed post op changes from L1-5, satisfactory bony alignment without instability. On 11/24/09, Dr. reviewed the recent imaging and did not recommend surgery but recommended a second opinion. Dr. evaluated the claimant on 11/30/09. Dr. impression was right sided back pain which was worse with standing and walking and seemed better with sitting and foraminal stenosis at L3-4. Dr. stated he could not determine the status of the fusion. Dr. authored a letter on 12/22/09 noting that the claimant had positive root tension testing for reproduction of symptoms in the lower extremity and numbness in the S1 pattern in the posterior thigh and posterior calf when seen on 09/23/09 and 11/18/09 exam findings of positive root tension sign for reproduction of back and leg pain. Dr. stated that the CT scan showed severe foraminal stenosis at L3-4 compressing the L3 nerve.

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

It is documented in this case that prior L3 transforaminal injections were provided in August and September of 2008. A follow up note of 09/17/08 outlined that the injections provided 50 percent relief of a 5-day duration. Notes indicate that L2-3 and L3-4 fusions were performed in 11/08. A CT scan on 11/09 outlined loosening of the right posterior L3 screw with right foraminal stenosis at L2-3. A recommendation for a right sided L3 nerve root block was made on 11/30/09. However straight leg raising was negative. Motor function was normal. There were no radicular findings documented. On overview of this case it is noteworthy that prior injection did not produce the desired level of relief for a 6-8 week period. Rather it produced relief for only 5 days. Furthermore, the requested injections are being planned in a spine where surgery has been performed since the first injection. It is important to note that radiculopathy is not objectively documented by way of motor sensory or reflex deficits on the most recent examinations. Based on all of the above, this request does not satisfy the ODG Guidelines. The reviewer finds that medical necessity does not exist for 1 Nerve Block/Transforaminal Epidural Steroid Injection at the Right L3 Level Under Fluoroscopy.

REFERENCES:

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter lumbar, epidural steroid injection

Transforaminal approach: Some groups suggest that there may be a preference for a transforaminal approach as the technique allows for delivery of medication at the target tissue site, and an advantage for transforaminal injections in herniated nucleus pulposus over translaminar or caudal injections has been suggested in the best available studies. (Riew, 2000) (Vad, 2002) (Young, 2007) This approach may be particularly helpful in patients with large disc herniations, foraminal stenosis, and lateral disc herniations

- (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)
- (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 required. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of 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-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE

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)