

## Notice of Independent Review Decision

**DATE OF REVIEW: APRIL 8, 2010 Amened Date: April 27, 2010**

**IRO CASE #:**

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

A dispute has arisen in regards to the medical necessity of a Lumbar Epidural Steroid Injection at L5-S1.

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

This physician is a Board Certified Orthopedic Surgeon with 35 years of experience as an orthopedic surgeon and a member of the American Academy of Orthopaedic Surgeons.

### **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 October 7, 2009, X-rays were taken of the cervical, thoracic, and lumbar spine, read by, D.C. Impression: Unremarkable.

On October 7, 2009, , M.D. evaluated the examinee. The examinee stated that she injured her back while performing some evasive maneuvers to avoid a collision. Impression: Cervical, thoracic, and lumbosacral spine sprains.

On November 10, 2009, MRI of the cervical spine was obtained, read by, M.D. Findings: 1. Disc spaces and vertebral body heights are maintained at each level. The bone marrow is within normal limits. The C1-2 articulation is unremarkable. 2. C2-3: There is no disc bulge, herniation or neural foraminal narrowing. C3-4: Posterior 2 mm disc protrusion/herniation presses on the thecal sac with no neural foraminal narrowing. C4-5: Posterior 2mm disc

protrusion/herniation presses on the thecal sac with no neural foraminal narrowing. C5-6: Posterior 1-2mm disc protrusion presses on the thecal sac with no neural foraminal narrowing. C6-7 and C7-T1: There is no disc bulge, herniation or neural foraminal narrowing. No facet disease or spinal stenosis is seen at any cervical level. The cervical spinal cord is within normal limits.

On November 10, 2009, MRI of the lumbar spine was obtained, read by, M.D. Findings: 1. Disc spaces and vertebral body heights are adequately maintained at each level. Focal hyperintensity in the posterior inferior L2 vertebral body is consistent with probable hemangioma. A similar finding is seen in the S3 segment of the sacrum. Each lumbar disc is adequately hydrated. 2. L1-2, L2-3, L3-4: There is no disc bulge, herniation or neural foraminal narrowing. L4-5: Best seen on T1-weighted sagittal imaging, there is posterior 1-2 mm disc protrusion pressing on the thecal sac with no neural foraminal narrowing. L5-S1: Best seen on T1-weighted sagittal imaging, there is posterior 1-2mm disc protrusion contacting the thecal sac at the midline with no neural foraminal narrowing. 3. No facet disease or spinal stenosis is seen any lumbar level. The conus terminates at the L1-2 level and is within normal limits.

On December 9, 2009, , M.D. evaluated the examinee for a Designated Doctors Examination. Extent of compensable injury: Cervical sprain and lumbosacral strain.

On December 15, 2009, , M.D., an orthopedic surgeon, evaluated the examinee. Impression: Protrusion at L4-5 and L5-S1. Protrusion and herniation, C3-4 and C4-5, and disk bulge of C5-6.

On January 12, 2010, , D.C. performed a Nerve Conduction (bilateral lower extremities) and Needle EMG (bilateral lower extremities). Nerve Conduction Impression: 1. Motor nerve conduction studies were within normal limits in the bilateral peroneal and right tibial nerves. The left tibial motor response reveals normal distal onset latencies, diminished CMAP amplitudes and normal NCV across the leg. 2. F-wave studies were within normal limits in the bilateral peroneal and right tibial nerves. The left tibial F-response is prolonged. Needle EMG Impression: There is electrophysiological evidence most consistent with active denervation processes involving the bilateral S1 nerves at this time. Upon comparison, there is a relatively inactive radicular process involving the left L5 nerve with reinnervation potential noted.

On March 1, 2010,, M.D., an orthopedic surgeon, performed a peer review on the examinee. Dr. opined that the examinee had reached MMI, could return to work, and the extent of compensable injury is that of a cervical/thoracic sprain/strain.

On March 4, 2010, Dr. performed a follow-up examination on the examinee. Impression: Protrusion at L5-S1 with S1 radiculopathy based on the examinee's EMG on January 12, 2010.

### **PATIENT CLINICAL HISTORY:**

On xx/xx/xx, the examinee sustained an injury to her cervical and lumbar spine, while “jerking” to avoid a motor vehicle collision, please note there was no contact between the two vehicles. The MRIs of the cervical and lumbar spine from November 10, 2009 show minimal disc protrusions of 1-2 mm (unremarkable).

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

The examinee’s physical examinations throughout the medical records are essentially normal, with no concrete evidence of radicular symptoms. The collective diagnosis throughout the medical records includes that of a lumbosacral sprain and cervical sprain. Furthermore, I would agree with Dr. that the January 12, 2010, NCV and EMG performed by, D.C. is useless and should have been performed by a PM&R physician or neurologist. Without concrete clinical support of radicular symptoms per the ODG an ESI is not indicated. Therefore, the Lumbar Epidural Steroid Injection at L5-S1 is not medically necessary.

### **ODG Treatment Procedure:**

#### **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. 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- 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)