

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: NOVEMBER 19, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

LESI L4-5

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

This physician is Board Certified by American Board of Physical Medicine and Rehabilitation 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 July 13, 2010, an MRI of the lumbar spine was performed. Impression: At L5-S1 a 5 or 6 mm broad based right lateralizing disk protrusion causes mild posterior displacement of the right S1 root above its nerve root sleeve origin.

Borderline right lateral recess encroachment is seen. At L4-5 a 3 or 4 mm disk protrusion caused mild concavity of the ventral thecal sac, without nerve root impingement as interpreted by M.D.

On July 14, 2010, an EMG/NCV of the lower extremities was performed. Impression: There is electrophysiologic evidence most consistent with active denervation/reinnervation processes involving the bilateral S1 nerve roots as interpreted by D.C.

On September 8, 2010, the claimant was evaluated by M.D., an anesthesiology and pain management physician. He grades his pain level at a 4/10 on a VAS scale. Bending, twisting, or sitting for any length of time aggravates the pain. It is of note that there was no documented musculoskeletal exam of the claimant's lumbar spine. Impression: Lumbar herniated discs. 2. Lumbar radiculopathy. Dr. prescribed compounded Gel #19, recommended continuation of physical therapy and a lumbar ESI.

On October 16, 2010, M.D., a designated doctor placed the claimant at MMI as of October 16, 2010 with a 0% whole person impairment rating. Per Dr. report, the claimant received physical therapy which helped. Spinal Examination: Palpation of the cervical spine was normal with no tenderness or spasm. Supine SLR was 80 degree bilaterally. Sitting SLR was 180 degrees bilaterally. Sitting Root test was negative bilaterally. ROM of the lumbar spine was within the normal limits. Testing of the spinal dermatomes was within normal limits bilaterally.

On October 20, 2010, the claimant was re-evaluated by, M.D. Nothing has changed since the last visit. A Lumbar ESI will be re-submitted for approval. Again of note there was no documented musculoskeletal exam of the claimant's lumbar spine.

On November 3, 2010, the claimant was re-evaluated by M.D. Nothing has changed since the last visit. The claimant is currently taking no medications. No documented musculoskeletal exam of the claimant's lumbar spine. A Lumbar ESI request will be re-submitted to an IRO for approval.

On September 23, 2010, D.O., an occupational medicine physician performed a utilization review on the claimant. Rationale for denial: Objective findings did not substantiate radiculopathy. Electrodiagnostic studies showed active denervation at the bilateral S1, however the request is for ESI at the L4-5 level. The MRI noted no nerve root impingement at the L4-5 level. There is no documentation provided to substantiate failure of conservative care. Therefore it is not certified.

On October 15, 2010, M.D. an anesthesiologist performed a utilization review on the claimant. Rationale for denial: The lumbar MRI revealed a L4-5 disk protrusion without nerve root impingement, and an EMG/NCV of the lower extremities demonstrated an active denervation involving the bilateral S1 nerve

roots, while this request is for the L4-5 level. Medical records sent for review also failed to document exhaustion of other recommended conservative treatments. Therefore it is not certified.

PATIENT CLINICAL HISTORY:

On xx/xx/xx, the claimant sustained an injury to the lumbar spine when he was lifting a box with chemicals from the floor when he developed pain in his lower back.

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

The previous decisions are upheld. Claimant appears to have had lower levels of conservative care in the form of medications and therapy as per Dr. note on September 8, 2010. However, that same note by Dr. on 9/8/10 does not include a physical exam of the lumbar spine. Therefore, there is no objective finding of radiculopathy on physical exam that correlated with imaging studies and electrodiagnostic studies. The Designated Doctor Evaluation on 10/16/10 also does not demonstrate nerve root irritation on provocative testing. Therefore, criteria for ESI according to ODG is not met.

ODG Guidelines:

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)**