

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 4, 2010 **AMENDED OCTOBER 7, 2010**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Transforaminal ESI 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 February 5, 2008, MRI of the right knee was performed. Impression: 1. Partial thickness tear of the ACL proximally which appears relatively high grade

in severity with lax distal fibers visualized. 2. Resolving contusional marrow edema of the posterolateral tibial plateau. 3. Joint effusion and Baker's cyst. 4. Grade II signal within the posterior of the medial meniscus as well as within the body of the lateral meniscus without discrete tear.

On February 28, 2008, M.D., orthopaedic surgeon, evaluated the claimant.
Assessment: Right knee ACL tear with resolving effusion.

On May 21, 2008, an MRI of the Lumbar Spine was performed. Impression: 1. Interforaminal leftward HNP at the L4-5. 2. Bilobed disc protrusions detailed level by level above. 3. Small focal aneurysm at the bifurcation of the aorta. Possibly a secular aneurysm. Ultrasound will be of value to fully characterize. 2.5-3 cm estimated diameter as interpreted by M.D.

On May 21, 2008, an MRI of the right shoulder was performed. Impression: 1. Findings suspicious for adhesive capsulitis. 2. Superolateral labral fraying and synovitis favored over the SLAP 2 tear. 3. Very small interstitial supraspinatus tendon tear with subjacent pseudocyst secondary to impingement. 4. Mild lateral outlet stenosis.

On May 22, 2008, , M.D., orthopaedic surgeon, evaluated the claimant.
Assessment: Right knee ACL tear with resolving effusion.

On August 5, 2008, D.C, evaluated the claimant. He has lumbar pain followed secondly by cervical pain. As the insurance carrier has denied the lumbar spine injury Dr. is only able to treat the cervical spine, right knee ACL tear, right shoulder injury, left foot and ankle injury.

On August 20, 2008, M.D, evaluated the claimant. He is currently on over the counter medications, which have provided no relief. He has tried some physical therapy for the knee with minimal benefit. He described the pain in his back as sharp with numbness and tingling in his shoulder down the left lower extremity to the knee. Impression: Cervicalgia. 2. Knee joint pain. 3. Thoracic spine. 4. Shoulder joint pain. Dr. prescribed Zanaflex, Lyrica, Tramadol and Celebrex.

On September 22, 2008, the claimant was re-evaluated by, M.D. He stated that he is 20-30% better with the medication regimen, but he still has a sharp pain in his back with burning to the left lower extremity.

On October 29, 2008, M.D., an orthopaedic surgeon, evaluated the claimant.
Assessment: L4/5 left sided disc herniation with significant foraminal stenosis and effacement of the left L4 nerve root with persistent lumbago and left lower extremity neuropathic type pain.

On December 10, 2008, a benefit dispute agreement (DWC FORM-24) was completed which all parties agreed that the compensable injury does extend to and include lumbar herniated disc at L4-5, atlas stenosis of the right shoulder, and superficial abrasions of the low back.

On December 31, 2008, the claimant was re-evaluated by, M.D. He describes his low back pain with numbness and stabbing into his left lower extremity. His muscle strength is 4/5 on the left and the right is 5/5. DTR's are 2+ throughout except in the left patellofemoral tendon where it is diminished.

On February 5, 2009, the claimant was re-evaluated by, M.D. He underwent a transforaminal epidural steroid injection two weeks ago and is doing well after the injection. He stated that he is 50-70% improved. Dr. recommended further physical therapy focusing on his back and left leg pain for strengthening and residual pain.

On March 5, 2009, M.D., orthopaedic surgeon, evaluated the claimant. Assessment: 1. Right knee ACL tear with resolved effusion. 2. Right shoulder partial thickness rotator cuff tear with impingement syndrome, AC joint arthritic change creating outlet stenosis.

On March 12, 2009, M.D., orthopaedic surgeon, evaluated the claimant. Assessment: 1. Right knee ACL tear with resolved effusion. 2. Right shoulder partial thickness rotator cuff tear with impingement syndrome, AC joint arthritic change creating outlet stenosis.

On April 15, 2009, D.C. disputed the claimant's impairment rating stating that the claimant should also be awarded a 10% whole person impairment rating for the right knee.

On April 22, 2009, the claimant was re-evaluated by, M.D. He stated that he has occasional left leg pain and there is always some back pain to some extent. He was instructed to continue his medication regimen, which includes Lyrica, Zanaflex and Tramadol.

On May 19, 2009, M.D. evaluated the claimant for MMI and impairment rating. Dr. placed the claimant at MMI as of March 18, 2009 and assigned the claimant a 10% whole person impairment.

On September 25, 2009, the claimant was re-evaluated by, M.D. He stated that he obtained about six months of excellent pain relief. He stated that the pain started increasing from the back, down the left leg about two months ago.

On November 9, 2009, the claimant was re-evaluated by, M.D. He had an Epidural Steroid Injection on October 14, 2009 and experienced a 70% reduction in pain and is able to work full time.

On August 16, 2010, M.D. a physical medicine/rehabilitation specialist, performed a utilization review on the claimant. Rationale for Denial: There was insufficient documentation submitted for review that demonstrated this patient had an increase in functional response, as well as decreased medication intake with previous injection. Therefore, it is not certified.

On September 3, 2010, M.D. evaluated the claimant. Assessment: Back pain lumbar. Radicular pain. Lumbar spondylosis without myelopathy.

On September 13, 2010, M.D. a physical medicine/rehabilitation specialist, performed a utilization review on the claimant Rational for Denial: ODG states that a repeat block is not recommended is there is inadequate response to the first block. There is no qualitative measurement from the prior ESI submitted for review. The documentation submitted for review does not support medical necessity. Therefore, it is not certified.

I have reviewed the letter from the claimant dated 10/4/10 which summarizes his situation since the injury on xx/xx/xx. I also reviewed the photographs submitted by the claimant.

PATIENT CLINICAL HISTORY:

On xx/xx/xx , the claimant sustained injuries to the low back, neck, left ankle/foot, right knee and right shoulder when he fell.

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

The previous decisions are upheld based on the claimant's inadequate response to the first block, and insufficient documentation submitted for review that demonstrated an increase in the claimant's functionality with his ADLS.

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)