

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 19, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inject Spine L/S (CD), Fluroguide for Spine Inject

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

This physician is a Board Certified Neurological Surgeon with 47 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, X-rays of the lumbar spine were performed. Impression: 1. Extensive postoperative changes of the lumbar spine are described above. At L4-L5, there is suspected chronic failure of union with mild instability. At L2-L3

and L3-L4, the fusion appears to be solidly ankylosed. 2. Severe degenerative spondylosis and facet arthrosis involves the L1-L2 and L5-S1 levels above and below this fusion as interpreted by M.D.

On xx/xx/xx, the claimant was evaluated by, M.D., a neurosurgeon. He is status post L3-4 decompression and fusion on April 5, 2010 and L2-3 and L4-5 fusion on January 23, 2004. He had his hardware removed on February 17, 2009. The claimant stated that his lower lumbar pain has gotten recently worse with leg pain. He is taking Hydrocodone, Savella, Flexeril, Lyrica and Neurontin. Physical exam revealed motor strength 5/5 in all major muscle groups and scattered trigger points. His range of motion is decreased.

On September 14, 2010, a CT of the lumbar spine was performed. Impression: L2-L3-L4-L5 fixation with pseudoarthrosis at L4-5, disc and facet degeneration at L5-S1 and L1-2, an bilateral foraminal stenosis at L5-S1, L4-L5 and L1-L2 as interpreted by, M.D.

On September 15, 2010, the claimant was re-evaluated by, M.D. His back pain is progressively worse with pain radiating down his leg. Reflex motor strength is 4+/5 in the right extensor hallucis longus and dorsiflexion weakness. There is slight plantar flexion weakness rated 5-/5. Dr. recommended a caudal ESI. His anti-inflammatory was changed to Celebrex and his Amrix to Parafon DSC.

There is a Medical Conference Note dated September 21, 2010 in which M.D. states that the claimant's last ESI was on December 20, 2007 that gave him almost 100% relief and greater than 60% relief for at least 6 months. He is on a home exercise program and will continue doing that.

On September 21, 2010, M.D., a neurological surgeon performed a utilization review on the claimant. Rationale for denial: The imaging studies have not confirmed radiculopathy and he does not have confirmed discogenic etc. on imaging. He has pseudoarthrosis, which probably is the reason for which he has worsened. With this claimant's multiple operations and failed procedures, the likelihood of getting any reasonable result is very limited. Therefore it is not certified.

On September 29, 2010, D.O., a neurological surgeon performed a utilization review on the claimant. Rationale for denial: There is no comprehensive assessment of postoperative treatment completed since the most recent surgery performed in February 2009. The claimant's physical examination does not adequately establish the presence of active radiculopathy. Additionally the presence of pseudoarthrosis which is the likely cause of the claimant's increased pain. Therefore it is not certified.

PATIENT CLINICAL HISTORY:

The claimant is a male, status post C3 through C6 ACDF on 10/25/06, but developed pseudoarthrosis. The claimant is taking multiple medications including Hydrocodone, Savella, Flexeril, Lyrica, and Neurontin.

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

Based on the ODG Guidelines, the previous decisions are upheld as there is no documentation on the claimant's physical examination that adequately establishes the presence of active radiculopathy.

Per the 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, 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)**