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Notice of Independent Review Decision

187510

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 03/29/2011

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified) Doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

One lumbar epidural injection under fluoroscopy

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- 12-07-10 Progress note from Dr.
- 01-13-11 Lumbar MRI read by Dr.
- 01-18-11 Progress Note from Dr.
- 02-07-11 Adverse Determination review for EMG/NCV lower extremities
- 02-08-11 Referral fax cover with patient profile from Dr.
- 02-18-11 Initial Consultation report from Dr.
- 02-25-11 Adverse Determination review
- 03-01-11 Preauthorization Appeal from Dr.
- 03-08-11 Adverse Determination review on Reconsideration
- 03-09-11 Request for IRO from the Claimant
- 03-10-11 Confirmation of Receipt of IRO request
- 03-10-11 Confirmation of Receipt of Request for IRO
- 03-11-11 Notice of Case Assignment

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a XX-year-old female employee who sustained an industrial injury to the low back on XX/XX/XXXX. She is status post surgery with lumbar fusion L4-5, L5-S1 in December 2001 and a right

shoulder surgery in 2004. Co-morbid conditions include non-insulin dependent diabetes mellitus.

The patient was reevaluated on December 7, 2010 for bilateral hip pain and right leg pain of 5-10/10 of one-year duration. Recent x-rays have shown some mild arthritis in the hips. She states a back brace is helpful. She requested refill of Neurontin. She is using 6 Tramadol daily. She has more pain with walking now and the right leg feels weaker. Her aching throbbing pain is worse with lying down. She is X'XX" and XXX pounds. Her history notes leg pain due arachnoiditis. She uses Motrin, Neurontin, Nexium, Tramadol and cardiac meds. She is not able to work. Lumbar flexion is to 60 degrees and extension to 5 degrees. Straight leg raise is positive on the right at 75 degrees. Right ankle reflex is absent. She has less sensation in the feet than elsewhere. Bilateral lower extremity motor deficits are noted. Recommendation is for updated MRI.

Updated lumbar MRI performed on January 13, 2011 was given impression: Overall not greatly changed. Evidence for lower lumbar arachnoditis. Unchanged perineural cysts in the lateral recess of L5-S1. Unchanged slightly inferior extruded disc herniation at L3-4 with mild impression both L4 nerve roots. Findings also note, moderately severe disc degeneration and 3 mm retrolisthesis at L3-4. Interiorly extruded broad-based disc herniation of 5 mm in AP dimension with mild impression on both L4 nerve roots in the lateral recess. At L4-5 and L5-S1, unchanged appearance of anterior fusion and instrumentation at both levels. Granulation tissue is noted about the S1 nerve root. Clumped lumbosacral nerve roots at L3-S1 consistent with arachnoiditis.

The patient was reevaluated on January 18, 2011 for chronic low back and bilateral leg pain, worse on the right. Flexeril was helpful for sleep but caused headaches. Sensation is impaired in the right and left toes. EHL strength is 4-/5 right and left. Recommend EMG/NCV then an appointment with the (pain management) specialist. Zanaflex is prescribed. Diagnosis is sciatic nerve lesion, lumbago, lumbosacral neuritis and intervertebral disc disorder, postlaminectomy syndrome.

Request for EMG/NCV of the lower extremities was not certified in review on February 7, 2011 as the reviewed report of January 18, 2011 did not document any recent changes on neurological examination. Additionally, there was no explanation of how the results would affect a treatment plan.

Fax note dated February 8, 2011 indicates the patient has been treated for low back pain due epidural fibrosis. She was managed with pain medications, but she is now worse and is not a surgical candidate.

The patient was provided an initial pain management consultation on February 18, 2011 for lower back pain, greater to the left. In 2001 she underwent a lumbar laminectomy and two-level fusion. She lost sensation for four days due a possible spinal fluid leak and had to undergo rehab to learn to walk again. He relates her pain is worse since the surgery. She has been managed by her primary provider for about four years, with medications. She is referred for further pain management and consideration of SCS. She rates her pain as 8/10 and relates numbness, tingling and weakness. She is X' XX" and XXX pounds. She has normal gait. Upper and lower extremity motor strength is 5/5. Achilles reflexes are symmetrically absent. Straight leg raise is positive at 35 degrees right and left. Active trigger points are noted. Left lower extremity sensation is diminished compared to the right. Recommendation is to treat the patient's bulging discs with a series of lumbar interspinal injections with trigger point injections; two, two weeks apart under fluoroscopic imaging. Consideration will be given for spinal cord stimulation once she completes conservative care. She was advised about an increase in glucose after injections.

Request for one lumbar epidural injection under fluoroscopy was considered in review on February 25, 2011 with recommendation for non-certification. The patient injured her spine in XXXX while doing a twisting motion. She had surgery at two spinal levels years ago. She has been managed with medications. She was reevaluated in pain management on February 18, 2011 for radicular complaints and the physical examination revealed: Intact power in the bilateral lower extremities with strength of 5/5 and positive straight leg raise and abnormal sensation which has been present since the onset of injury and post surgery. The patient has had lumbar surgical interventions and has some of the characteristics of radiculopathy present, however, the guides, which are evidence-based, require unequivocal evidence of radiculopathy which is not evidenced with loss of power in the lower extremities in this patient.

Appeal was made on March 1, 2011. The goal is to improve ROM and decrease pain allow the patient to be more functional. The patient complains of pain to the low back radiating down the right and left lower extremities to the toes with numbness and tingling to the toes. She has decreased sensation with light touch to the left lower extremity compared to the right and the right foot. Patellar reflexes are (symmetrically) 1+ and Achilles reflexes are (symmetrically) absent. MRI of 1/13/11 showed arachnoiditis, inferiorly extruded disc herniation L3-4 with mild impression of both L4 nerve roots. She may require SCS in the future but currently ESI is requested to prevent a more invasive procedure. The requested EMG/NCV has not been approved. She has been on medications and followed a walking program.

Request for reconsideration of one lumbar epidural injection under fluoroscopy was considered in review on March 8, 2011 with recommendation for non-certification. Documents reviewed include the letter of appeal of 3/1/11, preauthorization appeal of 2/18/11, lumbar MRI of 1/13/11 and progress notes of 12/7/10 and 1/18/11. The history is recounted unchanged from the initial review. Rationale for denial states, documentation does not support effectiveness of previous ESI such as decrease in pain score, greater than 50% relief for 6-8 weeks per ODG, increase in activity, increase in function, increase in sleep return to some form of vocation and/or decreased medical visits. The documentation does not support signs and symptoms that support definite nerve root involvement. Documentation does not meet ODG criteria like objective findings supporting radicular symptoms. There is no documentation supporting initially unresponsive to conservative treatment such as exercises, physical methods, NSAIDs and muscle relaxants.

Request was made for an IRO.

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

ODG: Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. Chronic duration of symptoms (> 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months.

The patient has been worse since a two-level fusion about 9 years prior. She has been doing worse for about a year with increased low back pain and bilateral radiating pain. It is not reported if she has undergone ESI in the past. In December the right leg feels weaker and right Achilles reflex is absent. Updated MRI is significant for mild impression on the L4 nerve roots associated with a slightly inferior extruded disc herniation at L3-4 and a 3 mm retrolisthesis at this level (We are not concerned with lower levels as they are fused and there is no ROM at those levels).

Based on the provider's reports, there are some indications of bilateral radiculitis (absent right ankle reflex, EHL strength of 4-/5 right and left and some sensation loss in the S1 area, mainly on the left). These findings however correlate with the lower lumbosacral root levels L5 and S1 which have already been fused and do not correlate with the disc pathology at L3-4.

In addition, the recent specialty examination was somewhat benign showing normal gait, full upper and lower extremity motor strength, symmetric reflexes, although straight leg raise was positive at 35 degrees right and left and left lower extremity sensation was (grossly) diminished compared to the right. The specialist proposed a plan of providing two ESI sessions concurrent with trigger point injections (a series of lumbar interspinal injections with trigger point injections; two, two weeks apart).

The level(s) desired for ESI are not stated. It is noted however, that the first stated goal for the injections is to improve range of motion and L3-4 level would be indicated as L4-5 and L5-S1 are fused and there would be no ROM at those levels. However, it was pointed out that the radicular pain in the legs are in the L5-S1 distribution.

The presence of true active radiculopathy in a dermatomal pattern remains equivocal based on the clinical findings and given the most recent specialty examination findings the patient would not be a candidate for ESI. It is also not clear if the patient would be able to engage in aggressive PT or that ESI would alter her long-term outlook considering arachnoiditis appears to be the primary etiology of her pain.

Therefore, my recommendation is to agree with the previous non-certification for one lumbar epidural injection under fluoroscopy.

The IRO's decision is consistent with the following guidelines:

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

__X___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

The Official Disability Guidelines 03-14-2011 Lumbar Chapter - Epidural Injections:

Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition.

Use for chronic pain: Chronic duration of symptoms (> 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months. The ideal time of either when to initiate treatment or when treatment is no longer thought to be effective has not been determined. Indications for repeating ESIs in patients with chronic pain at a level previously injected (> 24 months) include a symptom-free interval or indication of a new clinical presentation at the level.

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. 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.)