

# P&S Network, Inc.

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## Notice of Independent Review Decision

### MEDICAL RECORD REVIEW:

**DATE OF REVIEW:** 04/18/2011

**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**

Outpatient lumbar ESI plus Facet Block at L4-S1 64493 64494

### **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**

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 10-04-10 Orthopedic Visit report from Dr.
- o 11-17-10 Lumbar MRI read by Dr.
- o 01-12-11 Workers Comp intake notes from illegible
- o 01-27-11 Neurosurgical Consultation report from Dr.
- o 03-01-11 Reevaluation report from Dr.
- o 03-07-11 Adverse Determination letter
- o 03-21-11 Adverse Determination letter on reconsideration
- o 03-25-11 Request for IRO from the Claimant
- o 03-25-11 Confirmation of Receipt of Request for IRO
- o 03-25-11 Notice to P&S of Case Assignment
- o 03-30-11 Insurance Company Response

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records, the patient is a male who sustained an industrial injury to the low back on XX/XX/XXXX associated with a fall of about 14 feet. He landed on his feet and right side of his body and ended up on his back. He is followed for neck and low back pain by his orthopedic provider with a diagnosis of neck pain and lumbar sprain/low back pain (847.2).

Cervical MRI performed September 5, 2010 reportedly was given impression: A 1.5 to 2 mm central disc protrusion at C3-4. At C4-5 a 2.5 to 3 mm central subligamentous disc protrusion to herniation with total effacement of the cerebrospinal fluid to anterior cord with no central impression on the cord. There is mild right neuroforaminal stenosis. At C5-6, there is a 2 mm right central disc herniation with total effacement of the cerebrospinal fluid to the right anterior thecal cord with slight right central impression to

cord and examination to right neuroforamina with no compression to the right nerve root. There is mild right neuroforaminal stenosis. At C6-7, there is 2 mm left central disc protrusion with severe effacement of the cerebrospinal fluid to anterior to the cord.

Lumbar MRI performed September 5, 2010 was given impression: At L4-5, there is a 1-2 mm central bulge of the disc at L4-5 with slight to marginal impression on the dura. In addition, there is a discrete 3-3.5 mm left posterior disc protrusion to possible very small herniation into the left neuroforaminum with contiguity with but no overt impression on the left L4 nerve root. The disc is slightly hydrated and of borderline height. Findings also note, at L5-S1, there is 2 mm central bulge of disc with no impression on dura and no impression at the origin of nerve roots.

The patient was initially examined by his orthopedic provider on October 4, 2010 for chief complaint of neck pain. He fell from a vehicle when it suddenly tilted. He started having neck and back pain. He states he did not go to the ER until a few days later. X-rays were taken and he was prescribed ibuprofen with Tylenol and Codeine. He saw a physician who started him on a rehab program and ordered an MRI. He describes constant, moderate neck pain that radiates to the right shoulder blade and upper extremity. He cannot reach upwards or behind his back. In regard to the low back, he relates constant moderate pain that radiates to the right hip and posterior thigh/calf area. He has been off work since the accident. He does not smoke. He denies prior trauma, psychological issues or internal problems. He is X' XX" and XXX pounds. Cervical motion is mildly restricted with pain and muscle spasms noted. The right shoulder is tender. He has 100 degrees of shoulder flexion and "adduction." Impingement signs are positive. Low back exam notes muscle spasms, flexion of 50 degrees, positive right straight leg raise at 70 degrees and left at 80 degrees. He has good distal sensation and circulation. Right lower extremity motor strength is 4/5. Right Achilles reflex is decreased compared to the left. Cervical x-rays were taken and interpreted as essentially unremarkable. Lumbar x-rays show mild straightening of the lumbar lordosis and good disc heights. Right shoulder x-rays show type II acromion with positive impingement. Right hip x-rays are unremarkable. Cervical and lumbar MRI is cited (see above). Diagnosis is neck pain, low back pain, right shoulder rotator cuff syndrome, right shoulder pain and cervical radiculopathy. Recommendation is for upper and lower extremity nerve studies and right shoulder MRI. Celebrex, Ultracet and Soma are prescribed.

Intake note dated January 12, 2011 notes back, neck and right arm pain. He has decreased ROM. Some of the notes are illegible. He is using Vicodin and Flexeril.

The patient attended a neurological consultation on January 27, 2011. He reports neck pain of 10/10 that travels to the right arm with tingling in the hand. He describes constant sharp low back pain of 10/10 radiating from the his right hip down to his right leg, provoked when bending, walking, sitting, and getting up from the sitting position. He has no other body part complaints. He is using Hydromorphone. He has an unremarkable medical history with exception of an umbilical hernioplasty. Power is decreased in the right arm, and feeling is decreased in the C5-C6 distribution. There is lumbar spasm. Straight leg raise is positive at 40 degrees on the right and at 80 degrees on the left. Cervical MRI showed disc protrusions at C5, C6, and C7. Lumbar MRI showed disc bulges at L4-5-S1. Following the examination, he will be prescribed Tramadol 50 mg BID and Naproxen 375 mg BID and return in one week.

The patient returned to the neurologist on March 1, 2011. He reports persisting neck and low back pain that makes sleep difficult. He describes occasional neck spasms and weakness in the legs. He reports some dizziness and feels medications are not helpful. General systems check is unremarkable. The neck is supple without jugular distension. He is still falling and complaining of neck pain, right shoulder and arm pain, limited neck movement. He also has persisting pain in the low back and legs. Since he is very symptomatic, recommendation is for an epidural block and facet block at L4-5-S1. He should continue the Tramadol and Naproxen. Diagnosis is lumbago and cervicalgia.

Request for outpatient lumbar ESI plus Facet Block at L4-S1 was considered in review on March 7, 2011 with recommendation for non-certification. Per the reviewer, 8 pages of medical and administrative records were reviewed including medical reports with illegible notes. Lumbar MRI revealed no nerve root compression. Hip MRI was unremarkable. A peer discussion was attempted but not realized. The ODG criteria for ESI and facet blocks are reviewed. Rationale for denial states, clarification as to the intended dates of service is in order since the referenced guidelines do not recommend epidural blocks to be performed on the same day of treatment as facet blocks. Moreover, the physical examination did not document strength MMT, ROM measurements, sensory assessment or orthopedic maneuvers for the lumbar area and lower extremities. In addition, conservative care is advocated to be exhausted prior to these injections. This has not been documented as there are no PT reports or pain or symptom logs with medication use to validate maximized active rehabilitation efforts and pharmacology respectively.

Request for reconsideration outpatient lumbar ESI plus Facet Block at L4-S1 was considered in review on March 21, 2011 with recommendation for non-certification. 19 pages of records with duplicates were reviewed. A peer discussion was attempted but not realized. The prior denial rationale is noted. Per the reviewer, per the medical report of March 1 2011 the patient complains of low back pain. However, regarding the requested ESI, there is no documentation of radiculopathy, an imaging study documenting correlating concordant nerve root pathology, associated clinical findings such as loss of relevant reflexes, muscle weakness and/or atrophy of appropriate muscle groups, loss of sensation in the corresponding dermatome(s), and failure of conservative treatment including exercises, physical methods, NSAIDs and muscle relaxants. In addition regarding the requested facet block, there is no documentation of low back pain that is non-radicular and at no more than two levels bilaterally, failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks, and no more than 2 joint levels to be injected in one session. Furthermore, there is no documentation of a clear rationale for providing a lumbar ESI and a lumbar facet block at the same time.

Request was made for an IRO.

Insurance carrier response to the disputed services dated March 30, 2010 notes a lumbar radiculopathy or acute facet involvement is not substantiated by clinical examination findings or imaging studies. There is no documentation of physical therapy. Treatment has been medications only. ODG does not support ESIs without concurrent confirmation of radicular signs and symptoms along with a positive imaging study, which have not been documented. ODG also does not recommend facet injections to be performed at the same time as an epidural injection.

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

ODG criteria for ESI: 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). 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. ODG criteria for facet injections: Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.

Imaging shows a small 1-2 mm central disc bulge at L4-5 with slight to marginal impression on the dura. In addition, there is a discrete 3-3.5 mm left posterior disc protrusion to possible very small herniation into the left neuroforamen with contiguity with but no overt impression on the left L4 nerve root. The disc is slightly hydrated and of borderline height. At L5-S1, there is 2 mm central bulge of disc with no impression on dura and no impression at the origin of nerve roots. Nerve studies are not reported. Criteria for epidural injections require neurocompression via imaging or nerve studies showing radiculopathy. Criteria also require completion of a course of conservative care including physical methods, which has not been documented for this patient. None of the basic criteria for ESI are documented for this patient.

In regard to facet injections, there are no imaging findings suggesting facet hypertrophy or clinical examination findings suggesting facet-mediated pain versus discogenic pain. Facet injections and ESI's are also not recommended to be given concurrently, as the response to both would be confounded.

The first and second line reviewer rationale for denial continues to have merit.

Therefore, my recommendation is to agree with the previous non-certification for Outpatient lumbar ESI plus Facet Block at L4-S1 64493 64494.

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
- 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 Steroid 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.

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.)

The Official Disability Guidelines 03-14-2011 Lumbar Chapter: Facet joint diagnostic blocks (injections):

Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself.

Criteria for the use of diagnostic blocks for facet "mediated" pain:

Clinical presentation should be consistent with facet joint pain, signs & symptoms.

1. One set of diagnostic medial branch blocks is required with a response of = 70%. The pain response should last at least 2 hours for Lidocaine.
2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.
3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).
5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.
6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.
7. Opioids should not be given as a "sedative" during the procedure.
8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.
9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.
10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)
11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)]