CLAIMS EVAL

Utilization Review and Peer Review Services

URAC ACCREDITED

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 3-28-11 (AMENDED 3/30/11)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

64483 Selective Nerve Root block at left L4
77003 Fluoroscopy

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

American Boards of Physical Medicine and Rehabilitation and Pain Management

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

- Employer's First Report of Injury.
- Office visits on 10-2-07, 10-30-07, 11-20-07, 12-12-07, 1-9-08, 2-12-08, 2-19-08, 3-25-08, 4-22-08, 7-23-08, 9-22-08, 12-22-08, 3-20-09, 6-17-09, 12-15-09, 4-29-10, 5-19-10, 8-2-10, 11-17-10, and 2-18-11.
- Physical therapy evaluation on 10-9-07.
- Physical therapy on 10-30-07, 11-2-07, 11-7-07, 11-8-07, 11-13-07, 11-14-07 and 11-15-07.
- 11-20-07, an MRI of the lumbar spine.
- 12-1-10 Dr. reported he spoke with Dr. regarding the request for an epidural injection.
- 12-15-10 DO. performed a Utilization Review.
- 1-14-11 Dr. reported he spoke with Dr. regarding the request for epidural injection/nerve root block.
- 1-17-11 MD. performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Per The Employer's First Report of Injury, the claimant sustained a work injury on XX-XX-XX while employed at company. On this date, the claimant sustained a fall and injured her buttock/sacrum.

The claimant was seen by MD., on 10-2-07. It was noted this a XX-year-old-female who states that she was injured on the job on or about XX/XX/XX when she tripped over a bar that was perhaps a foot and a half off the ground and she fell backwards landing on her backside. Ever since then, she has had ongoing low back pain that she describes as aching and will radiate up into the thoracic region where she describes it as burning. She then has some pain that radiates into the right thigh and occasionally into the right groin. Initially, she had primarily hurt her thumb but this quickly resolved and the swelling had improved. Her back pain, however, has continued to be 6/10. It is worse at

night and affects her sleep and is aggravated with physical activity and she is also unable to tolerate any specific position such as standing, sitting, or lying down for any length of time, usually more than an hour. She eventually had some x-rays and she was told that these are normal. He did not have the films or the report. He had been asked to evaluate her and make further recommendations. She also wants to change treating doctors as apparently she has moved to the X area and is unable to drive down to X for treatments. In general, she is an obese female sitting in no acute distress on room air. She has a pleasant and appropriate affect and mood and is cooperative on today's exam. She has a normal gait pattern and is independent with mobility. Lumbar spine has no significant skin changes. She has some tenderness near the left PSIS. He was unable to assess her paraspinal muscles due to body habitus. Her pain is aggravated with extension and left side bending primarily. Lower extremity strength is normal and symmetric in all major muscle groups. There is no appreciable atrophy. Reflexes are 1+ at the patella and Achilles. FABERE maneuver on the left does increase her low back pain. Straight leg raise on the right does not significantly affect her leg pain. The evaluator recommended physical therapy, even some chiropractic treatment. The claimant was placed on Ultram and a trial of Lidoderm. If she does not improve then recommend an MRI.

On 11-20-07, an MRI of the lumbar spine showed no disc pathology at L1-2 or L2-3, with widely patent neural foramina. At L3-4, there is a 1-mm lateralizing disc bulge extending toward the neural foramina, with widely patent neural foramina, despite mild facet hypertrophic changes. At L4-5, there is a 2.2-mm broad-based disc bulge, minimally effacing the anterior thecal sac and extending into the neural foramina, with very minimal, if any, neural foraminal narrowing left greater than right, when combined with facet hypertrophy. There is no central spinal canal stenosis or herniation. At L5-S1, there is a lateralizing disc bulge measuring 1-2 mm extending toward the neural foramina, with widely patent neural foramina despite mild facet hypertrophy. No large herniation or severe central spinal canal stenosis is seen at any lumbar level.

Follow up with Dr. notes the claimant was provided with Trazadone and Flexeril. The request for MRI of the lumbar spine was denied. He continued to recommend the MRI.

Medical records reflect the claimant began a course of physical therapy. She attended physical therapy from 10-30-07 through 11-15-07.

Follow up with Dr. on 11-20-07 notes the claimant continues with significant pain. She has been out of work because she was fired. She is taking 9 Flexeril a day and does not find it beneficial. The claimant is using Lidoderm patches. The evaluator recommended facet injections at L4-L5 and L5-S1. The evaluator changed Flexeril to Tramadol and was continued on Lidoderm patches.

Medical records reflect the claimant continued to follow up with Dr.. The facet injections were denied. She was continued with medications.

Medical records reflect the claimant continued to followup with Dr. in 2008, and in 2009. She was continued on medications.

On 3-20-09, the claimant reported increased knee problems on the left side. The claimant was continued with medications to include Ultram and Flexeril.

On 4-29-10, Dr. reported the claimant stated that in the summer she began having dysesthetic pain in the hands, worse on the left. She denied any specific injury. She is currently taking medications for chronic back pain.

The claimant continued to followup with Dr. in 2010. She was continued on medications.

12-1-10 Dr. reported he spoke with Dr. regarding the request for an epidural injection. He reviewed with her the claimant's case and obviously the fact that it is now almost X years old and the fact that her radicular complaints really have not been consistent and really all the way down the leg until recently which suggests that her current symptoms are likely not related to her original injury and he felt this is a very valid argument. She would therefore recommend against approving the injection.

Follow up with Dr. on 12-6-10 notes the claimant continues with pain across the low back but more significant and what has really been worsening with constant radiating pain down the back of the left leg. On exam, she does not have significant atrophy, normal gait pattern slightly favoring the left side. Sensation is intact. She has mild weakness in the left dorsiflexors compared to the right. The evaluator recommended a L4 nerve root block for further diagnostic confirmation and hopefully therapeutic effect. He refilled her Ultram, continued the claimant on a home exercise program and continued her with a home exercise program.

12-15-10 DO., performed a Utilization Review. It was her opinion that the necessity of diagnostic epidural steroid injection under the remote injury claim is not established based on the serial record. The MRI is essentially unremarkable over X years out from the alleged incident date.

1-14-11 Dr. reported he spoke with Dr. regarding the request for epidural injection/nerve root block. She felt that her current symptoms were not due to her XXXX injury. This is something that he had discussed with the claimant before and it only submitted the request in order to satisfy the patient. At this point, he will recommend to the patient that if she wants to pursue treatment, it needs to be outside of the work comp insurance carrier.

1-17-11MD., performed a Utilization Review. It was her opinion that nothing in the serial records supports spinal injections, with there being no verified radiculopathy resulting from the alleged work incident in XXXX.

On 2-18-11MD., the claimant's has been denied through workers' comp and he discussed with her again that frankly he had to agree with them that her current symptoms appear totally different and unrelated to her work-related ones and he will try to assist her in essentially getting transitioned over to her primary insurance, which he felt is appropriate. She is obviously having a lot of emotional issues as well. She states that she been drinking alcohol a lot, that she is having difficulty with individuals at work. She is flat out requesting to get on disability and apparently has discussed getting on short-term disability with her primary care doctor. She still has to get her carpal tunnel surgery done as well in addition to taking care of her back and legs. She is rating this pain as about an 8/10. She has been recently put on Klonopin through her primary care doctor. She is otherwise taking Zanaflex typically 2 at night. At this point she feels like the Ultram ER is not very helpful for her. She is X feet X inches and weighs XXX pounds. Pulse is 70. Blood pressure is 120/72. In general she is an obese female sitting in no distress on room air. She has a depressed affect and is somewhat tearful at times during our interview. She has no weakness, however, or any sensory or reflex deficits in the lower extremities and no significant atrophy in the calf and thigh. She does have discomfort primarily in the left buttock. He reviewed his concerns with her emotional status and he would have her get evaluated by one of the psychologists to make some recommendations. In the meantime again we will help facilitate her transition to her primary insurance from workers' comp which again he felt was not appropriate to be addressing her current symptoms and once he can do this he will get her nerve root block and possibly surgical consultation through her insurance company. In the meantime he encouraged her to continue with her home exercises as best as she can. As far as a correctional disability, she is certainly not totally disabled at least from a physical aspect. She may require some short term disability following her carpal tunnel surgery or certainly following some of the interventions for her back but at this point he would be completely against her quitting her job. Obviously she would leave her insurance or would have to spend a lot for COBRA in that case and he discussed with her that even if she were to get on Medicare that it may take years for that process to occur.

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

BASED ON THE RECORDS PROVIDED, THE REQUEST FOR A 64483 SELECTIVE NERVE ROOT BLOCK AT LEFT L4 AND 77003 FLUOROSCOPY IS NOT REASONABLE OR MEDICALLY INDICATED. THE MRI FINDINGS DO NOT JUSTIFY THE BLOCK AND THERE IS NO VERIFIABLE RADICULOPATHY ON EXAM. THEREFORE, THE REQUEST FOR THE LEFT L4 NERVE ROOT BLOCK AND 77003 FLUOROSCOPY IS NOT MEDICALLY NECESSARY.

ODG-TWC, last update 3-14-11 Occupational Disorders of the Low Back – epidural steroid injection: 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.
Short-term symptoms: The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. (Armon, 2007) Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function or return to work. There is no high-level evidence to support the use of epidural injections of steroids, local anesthetics, and/or opioids as a treatment for acute low back pain without radiculopathy. (Benzon, 1986) (ISIS, 1999) (DePalma, 2005) (Molloy, 2005) (Wilson-MacDonald, 2005) This recent RCT concluded that both ESIs and PT seem to be effective for lumbar spinal stenosis for up to 6 months. Both ESI and PT groups demonstrated significant improvement in pain and functional parameters compared to control and no significant difference was noted between the 2 treatment groups at 6 months, but the ESI group was significantly more improved at the 2nd week. (Koc, 2009)
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. (Hopwood, 1993) (Cyteval, 2006) 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.
Transforaminal approach: Some groups suggest that there may be a preference for a transforaminal approach as the technique allows for delivery of medication at the target tissue site, and an advantage for transforaminal injections in herniated nucleus pulposus over translaminar or caudal injections has been suggested in the best available studies. (Riew, 2000) (Vad, 2002) (Young, 2007) This approach may be particularly helpful in patients with large disc herniations, foraminal stenosis, and lateral disc herniations. (Colorado, 2001) (ICSI, 2004) (McLain, 2005) (Wilson-MacDonald, 2005)
Fluoroscopic guidance: Fluoroscopic guidance with use of contrast is recommended for all approaches as needle misplacement may be a cause of treatment failure. (Manchikanti, 1999) (Colorado, 2001) (ICSI, 2004) (Molloy, 2005) (Young, 2007)
Factors that decrease success: Decreased success rates have been found in patients who are unemployed due to pain, who smoke, have had previous back surgery, have pain that is not decreased by medication, and/or evidence of substance abuse, disability or litigation. (Jamison, 1991) (Abram, 1999) Research reporting effectiveness of ESIs in the past has been contradictory, but these discrepancies are felt to have been, in part, secondary to numerous methodological flaws in the early studies, including the lack of imaging and contrast administration. Success rates also may depend on the technical skill of the interventionalist. (Carette, 1997) (Bigos, 1999) (Rozenberg, 1999) (Botwin, 2002) (Manchikanti , 2003) (CMS, 2004) (Delport, 2004) (Khot, 2004) (Buttermann, 2004) (Buttermann2, 2004) (Samanta, 2004) (Cigna, 2004) (Benzon, 2005) (Dashfield,

2005) (Arden, 2005) (Price, 2005) (Resnick, 2005) (Abdi, 2007) (Boswell, 2007) (Buenaventura, 2009) Also see Epidural steroid injections, “series of three” and Epidural steroid injections, diagnostic. ESIs may be helpful with radicular symptoms not responsive to 2 to 6 weeks of conservative therapy. (Kinkade, 2007) Epidural steroid injections are an option for short-term pain relief of persistent radiculopathy, although not for nonspecific low back pain or spinal stenosis. (Chou, 2008) As noted above, injections are recommended if they can facilitate a return to functionality (via activity & exercise). If post-injection physical therapy visits are required for instruction in these active self-performed exercise programs, these visits should be included within the overall recommendations under Physical therapy, or at least not require more than 2 additional visits to reinforce the home exercise program.
With discectomy: Epidural steroid administration during lumbar discectomy may reduce early neurologic impairment, pain, and convalescence and enhance recovery without increasing risks of complications. (Rasmussen, 2008)
An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy. (Staal-Cochrane, 2009) Recent studies document a 629% increase in expenditures for ESIs, without demonstrated improvements in patient outcomes or disability rates. (Deyo, 2009) There is fair evidence that epidural steroid injection is moderately effective for short-term (but not long-term) symptom relief. (Chou3, 2009) This RCT concluded that caudal epidural injections containing steroids demonstrated better and faster efficacy than placebo. (Sayegh, 2009)

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.)

ODG-TWC, last update 3-14-11 Occupational Disorders of the Low Back - Fluoroscopy: Fluoroscopy is considered important in guiding the needle into the epidural space, as controlled studies have found that medication is misplaced in 13% to 34% of epidural steroid injections that are done without fluoroscopy. See Epidural steroid injections (ESI's).

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)**