

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: February 1, 2011 **Amended Date:** February 3, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right L5, S1 Transforaminal ESI (64493, 64494)

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

This physician is a Board Certified Pain Management and Anesthesiology Physician with 40 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 April 17, 2009, an MRI of the lumbar spine was performed. Impression: 1. Compression deformity of the L1 vertebral body but there is no retropulsion or fracture fragments and no associated bone marrow edema to suggest that this is

acute. 2. Mild disc degeneration is noted throughout the lumbar spine. Mild congenital spinal canal narrowing is seen. There is also mild spinal stenosis throughout the lumbar spine. 3. At L5-S1 there is posterior disc bulging and is superimposed right paracentral disc protrusion, which causes mild right sided neural foraminal narrowing and posterior displacement of the intrathecal right traversing S1 nerve root. Multilevel mild facet degeneration as interpreted by M.D.

On September 3, 2010, the claimant was evaluated by M.D. He has undergone an ESI which did not help. His symptoms are worse with flexion compared to extension. He has variable right lower extremity referred paraesthesias. He has tried Hydrocodone, Naproxen and Skelaxin and is not taking any medications currently. DTR's are normal. Slight positive Hoffman's response more on the right than left. Tenderness along midline at L4-S1. There is some radicular pain in the right hip and lower extremity consistent with a L5 distribution. A lumbar right L5 transforaminal epidural injection was recommended.

On September 23, 2010, the claimant was re-evaluated by M.D. He has had no improvement in regards to the lumbar spine. Impression: Cervicospinal myofascial pain. Lumbar disc protrusion with associated lumbar radiculopathy.

On November 23, 2010, the claimant was re-evaluated by M.D. His lumbar spine continues to bother him. He sees M.D. for primary medical management. He is having some right foot sensory changes with tingling. A lumbar ESI was again recommended. Impression: Cervical facet syndrome. Possible cervical radiculopathy. Lumbar pain likely facet in origin with associated referred right lower extremity pain. Possible right S1 radiculopathy.

On December 9, 2010, M.D., a Physical Medicine and Rehabilitation Physician performed a utilization review on the claimant. Rationale for denial: A lumbar MRI obtained on 4/17/09 revealed findings consistent with compression deformity of the L1 vertebrae, with a disc bulge at the L5-S1 level. The records available for review indicate that past treatment included an attempt at the lumbar epidural steroid injection. The records available for review do not document if there was a significantly positive response to previous attempts at treatment in the form of a therapeutic injection to the lumbar region. Therefore it is not certified.

On December 30, 2010, M.D., a cardiovascular surgeon performed a utilization review on the claimant. Rationale for denial: There is no comprehensive assessment of treatment completed to date of the patient's response thereto submitted for review. The patient's physical examination fails to establish the presence of active lumbar radiculopathy, and there are no imaging studies/electrodiagnostic results provided to support the diagnosis. Therefore it is not certified.

PATIENT CLINICAL HISTORY:

The date of injury is xx/xx/xx.

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

Per the ODG Guidelines the previous decisions are upheld. Based on the medical records provided for review there is a lack of documentation in the physical examinations that establish the presence of lumbar radiculopathy. Furthermore, per Dr. note on September 3, 2010, the claimant did not receive relief from the previous ESI which establishes a lack of improvement from the initial ESI. Based on the above-mentioned the previous decisions are upheld.

Based on the ODG:

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. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. (Andersson, 2000) 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.)

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)**