

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 12, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar ESI Right L4-5, L5-S1, 62282, 62319

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

This physician is a Board Certified Physical Medicine and Rehabilitation with 15 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

Per the Employer's First Report: The claimant was injured while lifting 40-50 lbs.

In December 2001, M.D., evaluated the claimant. Exam: He has full range of motion of the back and legs with left lumbosacral spasm. Assessment: Lumbosacral strain.

In January 2002, MRI of the Lumbar spine was performed, read. Impression: 1. Posterior protrusion of disc material posteriorly on the left at L2-3 and L4-5. 2. Spinal stenosis is seen at L2-3 and L3-4. 3. Moderate foraminal encroachment is seen bilaterally at L4-5, greater on the left, and moderate to severe foraminal encroachment is seen at L5-S1, greater on the left, secondary to facet hypertrophy. 4. Enumeration of the vertebral segments may be best demonstrated with comparison of plain lumbar radiographs, as there does appear to be a rudimentary disc between S1 and S2 on this study.

In January 2002, re-evaluated the claimant. Exam: He reports numbness along the L3 dermatome without lack of sensations. There is full range of motion of the leg with good strength and deep tendon reflexes. Assessment: Herniation of L2-3 by MRI scan.

In February 2002, a neurosurgeon, evaluated the claimant. Medications: Ultram, Skelaxin, and Etodolac. Past Surgical History: Lumbar Disk Surgery in 1986. Exam: Motor testing shows normal strength. He has numbness extending what matches a probable L2 or L3 dermatome that appears to be the most significant but there is some sensory loss in the L4, L5, and S1 dermatomes as well. DTRs are hyperactive in the knee jerks and ankle jerks. SLR causes radicular pain about 60 degrees on the left. Right SLR is negative. Impression: Severe degenerative lumbar disk disease with multilevel radiculopathy.

In February 2002, EMG/NCV was performed. Impression: Left Lumbosacral polyradiculopathies. Impingement of the left L4 possible L3 nerve root is confirmed by ongoing denervation of muscles supplied by this nerve root in the left leg.

In March 2002, a neurosurgeon, re-evaluated the claimant. Impression: The claimant is unimproved. Plan: Multilevel lumbar decompression.

In March 2002, a neurosurgeon, performed a peer review on the claimant. Impression: The surgery requested is not medically necessary.

In April 2002, M.D. performed a caudal ESI with catheter.

In May 2002, M.D. performed casudal ESI with catheter.

In May 2002, a neurosurgeon, performed a peer review on the claimant. Impression: At this time, it is appropriate for the claimant to have a decompressive lamictomy with a 2-day inpatient stay.

In June 2002, M.D. performed a L3, L4, L5 decompression without complications.

In June 2002, MRI of the Lumbar spine was performed, read. Impression: Extensive scar or edema after laminectomy from L2 down to L5-S1. Disc protrusion between L2-3 that also effaces the thecal sac anteriorly.

In June 2002, CT of the Lumbar Spine, post myelography was performed, read. Impression: 2 disc bulges, one at L4-5 and the other at L1-2.

In June 2002, M.D. performed a lumbar wound exploration. Postoperative diagnosis: Polyradiculopathy after the lumbar laminectomy. Probable wound infection.

In August 2002, M.D. re-evaluated the claimant. Impression: Satisfactory recovery to date following multilevel lumbar decompression with complications.

In December 2002, MRI of the Lumbar Spine was performed, read. Impression: Improvement from 6/18/02 with the thecal sac no longer compressed by the posterior collection. Several levels still have posterior spurring and small disc protrusion with foraminal encroachment at several levels as described above. There is also some enhancing scar around the thecal sac at L4-5 level.

In December 2002, M.D. performed an IME on the claimant. Medications: Lortab. Lumbar range of motion is decreased. He has some palpable spasm on the left side. Assessment: He is known to have lumbar radiculopathies in at least 2 levels on the left side, L3 and L4 and possibly at other levels. He has weak left lower extremity and paresthesias in the left leg. He has severe and constant pain that interferes with activities of daily living and sleep.

In January 2003, D.O. performed a DDE on the claimant. Placed the claimant not at MMI pending pain management consultation.

In February 2003, M.D. evaluated the claimant. Exam: Back exam reveals tenderness to palpation in the lumbar spine. DTRs are slightly less on the left side. Assessment: Low back pain with left greater than right lower extremity radiculopathy.

In March 2003, M.D. performed an EMG/NCV on the claimant. Impression: Chronic left L4 radiculopathy. There are no signs of active or ongoing axonal loss at this time. The L3, L5, and S1 nerve roots appear to be intact.

In March 2003, M.D. performed the following: bilateral facet injections at L3-4, L4-5, and L5-S1, caudal epiduralgram myelogram without dural puncture, caudal epidural catheter placement with injection of ESI at L4-5 on the left side, and nerve root decompression at L4-5 on the left side.

In May 2003, M.D. performed the following: bilateral facet injections at L3-4, L4-5, and L5-S1, cadual epiduralgram myelogram without dural puncture, caudal epidural catheter placement with injection of ESI at L4-5 on the left side, and nerve root decompression at L4-5 on the left side.

In June 2003, preformed a second DDE on the claimant and placed the claimant not at MMI pending further treatment.

In June 2003, M.D. performed the following: bilateral facet injections at L3-4, L4-5, and L5-S1, cadual epiduralgram myelogram without dural puncture, caudal epidural catheter placement with injection of ESI at L4-5 on the left side, and nerve root decompression at L4-5 on the left side.

In July 2003, M.D. performed an RME on the claimant. Impression: Lumbosacral back strain with multilevel degenerative disk disease and degenerative joint disease. Chronic low back pain syndrome with left L4 radiculopathy and possible multiple levels of radiculopathy. Failed back surgery syndrome.

In September 2003, MRI of the lumbar spine was performed, read. Impression: Postsurgical changes with degenerative disk bulges at L4-5 and L5-S1. There is no evidence of recurrent disk herniation, although there appears to be a small annular tear at L4-5. Small Annular tear and disk bulge at L2-3.

In November 2003, M.D. performed RFTC facets left L1-2, L2-3, L3-4, L4-5 and L5-S1.

In January 2004, M.D. preformed an RME on the claimant. Dr. determined the claimant was not at MMI pending further treatment.

In January 2004, NCV/EMG was performed, read. Impression: Old Chronic left L4 radiculopathy and possible old right L4 radiculopathy also. No signs of L5 or S1 radiculopathy on either side.

In February 2004, Ph.D. evaluated the claimant. Assessment: Former chemical dependent claimant now presents with severe anger and frustration in regards to what appears to be complex regional pain syndrome.

In February 12, 2004, M.D. performed the following: bilateral facet injections at L3-4, L4-5, and L5-S1, cadual epiduralgram myelogram without dural puncture, caudal epidural catheter placement with injection of ESI at L4-5 on the left side, and nerve root decompression at L4-5 on the left side.

In February 25, 2004, M.D. placed the claimant at MMI with a 14% whole person impairment.

In April 2004, M.D. performed the following: caudal epiduralgram myelogram without dural puncture, caudal epidural catheter placement with injection of ESI at L4-5 on the left side.

In September 2004, M.D. performed the following: nerve root decompression at L4-5 on the left side, Tun-L catheter placement with injections of steroid solution an Marcaine at L4-5 nerve roots left.

In October 2004, M.D. performed a peer review on the claimant. Impression: The claimant sustained a lumbar strain and has been treatment this while time for pre-existing conditions. Therefore, the compensable injury has resolved.

In January 2005, M.D. performed the following: caudal epiduralgram myelogram without dural puncture, caudal epidural catheter placement with injection of ESI at L4-5 on the left side, and nerve root decompression at L4-5 on the left side.

In May 2005, Ph.D. evaluated the claimant. Impression: Major depressive disorder.

In June 2005, M.D. performed the following: caudal epiduralgram myelogram without dural puncture, caudal epidural catheter placement with injection of ESI at L4-5 and L2-3 on the left side, and nerve root decompression at L4-5 and L2-3 on the left side.

In August 2005, M.D. performed the following: caudal epiduralgram myelogram without dural puncture, caudal epidural catheter placement with injection of ESI at L4-5 and L2-3 on the left side, and nerve root decompression at L4-5 and L2-3 on the left side.

In April 2006, M.D. performed the following: caudal epiduralgram myelogram without dural puncture, caudal epidural catheter placement with injection of ESI at L4-5 on the left side, and nerve root decompression at L4-5 on the left side.

In September 2006, performed the following: caudal epiduralgram myelogram without dural puncture, caudal epidural catheter placement with injection of ESI at L4-5 on the left side, and nerve root decompression at L4-5 on the left side.

In November 2006, M.D. performed the following: caudal epiduralgram myelogram without dural puncture, caudal epidural catheter placement with injection of ESI at L4-5 on the left side, and nerve root decompression at L4-5 on the left side.

In April 23, 2007, M.D. performed a peer review on the claimant. Impression: unchanged.

In July 2007, M.D. performed the following: caudal epiduralgram myelogram without dural puncture, caudal epidural catheter placement with injection of ESI at L5-S1 on the left side, and nerve root decompression at L5-S1 on the left side.

In October 2007, M.D. performed the following: bilateral facet injections at L3-4, L4-5, and L5-S1 and sacroiliac joint injection.

In December 2007, performed the following: caudal epiduralgram myelogram without dural puncture, caudal epidural catheter placement with injection of ESI at L5-S1 on the left side, and nerve root decompression at L5-S1 on the left side.

In March 13, 2008, M.D. performed a left sacroiliac joint injection.

In May 20, 2008, M.D. performed an RME on the claimant. Exam: Seated SLRs were performed: on the right seated SLR elicited right SI joint pain but no sciatica and on the left seated SLR elicited left bullock pain and left anterior thigh pain but no true sciatica. Right and left FABER maneuver was positive for SI joint pain. Diagnosis: Chronic low back pain.

In June 26, 2008, M.D. performed the following: caudal epiduralgram myelogram without dural puncture, caudal epidural catheter placement with injection of ESI at L5-S1 on the left side, and nerve root decompression at L5-S1 on the left side.

In December 2008, M.D. performed a lumbar epidural catheter assisted epidurogram without dural puncture at L4-5 and L5-S1 on the left side.

In March 2009, M.D. performed right sacroiliac joint injection.

In August 2009, M.D. performed a lumbar epidural catheter assisted epidurogram without dural puncture at L4-5 and L5-S1 on the left side.

In May 2010, M.D. evaluated the claimant. The last time we did an ESI on this claimant was back on August 25, 2009 which gave him significant pain reduction. He obtained about 7 months of 90% pain reduction. DTRs are hyper reflexic. Assessment: Low back pain.

In December 2010, M.D. evaluated the claimant. Currently he is having severe low back pain with lower extremity radiculopathy and pain that extends into the groin region. DTRs are hyper reflexive. SLR to 25 degrees with pain in dorsiflexion makes pain worse which causes radiation of pain into the lower extremities. Assessment: Low back pain which is severe excruciating intractable with lower extremity radiculopathy.

In December 2010, M.D. performed a utilization review. Reason for Denial: the documentation submitted for review is not inclusive of a current MRI,

electrodiagnostic studies, or current comprehensive physical exam, indicating radiculopathy.

In January 2011, M.D. performed an utilization review. Reason of Denial: Unable to reach requesting doctor. The claimant complains of chronic low back pain limited documentation of any neurologic deficits. It is unclear what conservative measures the claimant has undergone and if any progress was made.

Pain Management SOAP notes from 3/12/03 to 12/16/10 were submitted.

PT notes from 8/8/02 to 10/4/02 were submitted.

PATIENT CLINICAL HISTORY:

History of chronic lumbar pain since 2001.

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

The previous decisions to deny ESI are upheld. The following ODG Low Back Chapter Criteria for ESI are not met:

1. There are no clear objective physical findings suggestive of radiculopathy and there is no corroboration with past MRI's or EMG's.
2. Other than surgery and injections, the submitted clinicals do not indicate any previous conservative measures such as medications, therapy or home exercise.

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)