

P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 01/26/2011

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

Third left LESI at L4-5 with fluoroscopic guidance, outpatient 62311, 72275 (PNR 77003)

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 07-21-10 Lumbar MRI read by Dr.
- o 07-27-10 History and Physical Exam, from Dr.
- o 08-09-10 Nerve Conduction Studies and EMG read by Dr.
- o 08-11-10 Procedure report from Dr.
- o 08-11-10 Discharge Summary from Dr.
- o 08-17-10 Medical notes including 08-21-10 and 12-14-10, unsigned
- o 09-16-10 Final report from Dr.
- o 09-29-10 Procedure report from Dr.
- o 09-29-10 Discharge summary from Dr.
- o 12-08-10 Nurse notes from RN
- o 12-15-10 Fax cover request for LESI from Dr.
- o 12-20-10 Notice of Adverse Determination and review
- o 01-07-11 Notification of Reconsideration Determination
- o 01-10-11 Request for IRO from the Claimant
- o 01-11-11 Confirmation of Receipt of Request for IRO from TDI
- o 01-12-11 Notice to P&S of Case Assignment from TDI

PATIENT CLINICAL HISTORY (SUMMARY):

According to the medical records and prior reviews, the patient is a male employee who sustained an industrial injury to the low back on xx/xx/xx when he slipped and fell. He heard a pop in his back and felt low back and left leg pain. Co-morbid conditions include diabetes mellitus, diagnosed 20 years prior, obesity (BMI 31.3) and hemoglobin A1c ranging from 6 to 7.

Lumbar MRI performed on July 21, 2010 was given impression: 1. This patient has a congenitally small central canal due to short pedicles. This abnormality as well as disc disease and facet disease causes varying degrees of central canal stenosis from L2-3 through L4-5. 2. There is prominent disc herniation at L4-5 (disc material extends caudally at both the right paracentral canal and left paracentral regions). 3. There are varying degrees of bilateral foraminal narrowing and recess narrowing and canal stenosis (moderate central stenosis with AP diameter of the canal at 6 mm at L4-5).

The patient was evaluated on July 27, 2010. His back pain improved about the time he began to feel leg pain (left hip, posterior thigh and calf). There is no numbness or weakness in his legs. He rates the pain as 7/10 in the AM. Coughing and sneezing increase the pain. Bending and stooping do not increase the pain. He has no bowel or bladder problems. Examination is significant for absent left ankle jerk. Left straight leg raise is positive at 60 degrees, Sensation is intact. Motor strength is good with exception of weakness in left dorsiflexion. MRI shows an extruded disc at L4-5 on the left "this was missed by the radiologist. The left L5 root is compressed by the disc fragment." EMG and LESI are planned.

Nerve studies were done on August 9, 2010. He has low back and left leg pain that exacerbates with coughing or sneezing. He has leg weakness but he has not fallen. MRI showed an extruded disc on the left at L4-5. He has paresthesias into the left thigh and calf. He is 5' 7" and 200 pounds. He can flex his left hip to 90 degrees before pain is elicited. Light touch is intact. He is able to walk on his heel and toes. Reflexes are normal. There is slight weakness of left toe flexion. The study is interpreted as showing possible left L5 radiculopathy.

The patient underwent an initial lumbar epidural steroid injection (LESI) at L4-5 on August 11, 2010 with 120 mg of DepoMedrol and 2 ccs of Fentanyl. The discharge note states the pain improved considerably following the injection.

Medical report dated August 17, 2010 indicates his pain improved for several days following the LESI, but has returned. His foot dorsiflexor weakness continues. He will need a CT myelogram to assess the HNP. On September 21, 2010 his back pain persists, but his leg pain has cleared. His CT myelogram shows the pathology seen on MRI. Surgery will be cancelled and another LESI scheduled.

CT myelogram conducted September 16, 2010 was given impression: Osteoarthritis. Degenerative disc disease. Mild central and lateral spinal stenosis L4-5 as detailed (broad-based disc protrusion present at L4-5 resulting in mild central and lateral spinal stenosis).

A second LESI was administered on September 29, 2010 at L4-5 using 120 mg of Depomedrol and 2 ccs. of Fentanyl. The discharge note states his pain improved considerably following the injection.

Nursing note dated December 8, 2010 indicates the patient called and is being referred back by his PCP. He states his left leg is still weak and it is hard for him to lift his left leg. His back pain is mostly in his low middle back.

On December 14, 2010 his back pain has recurred. Another LESI is planned. After further review of his CT scan, he appears to have a HNP at L4-5 that extends below the disc space with mass effect worse on the right.

On December 15, 2010 request was made for LESI with procedures 62311, 72275 and 77003.

Request for third left LESI at L4-5 with fluoroscopic guidance; outpatient 62311, 72275 (PNR 77003) was considered in review on December 20, 2010 with recommendation for non-certification. According to the reviewer, the patient injured his low back in a slip and fall incident. He has a diagnosis of lumbar disc displacement. He is using Diovan 160-25 daily, Glucotrol 5 mg daily, Tricor 145 mg daily, amlodipine (dosage and frequency not stated), metformin ER 500 mg 2 tabs in the AM and 1 QPM, terazosin 5 mg daily, Lotrel 5-20 mg daily, omeprazole 20 mg PRN, Flexeril 10 mg 1 po QHS, naproxen 500 mg BID, and Norco 10-325 mg, 1-2 tabs every 4 hours PRN. He underwent lumbar epidural steroid injection (LESI) at L4-5 on August 11, 2010 with several days of improvement (per report 8/17/10). He had a kidney cyst removed in 1989. He had EGD done in January 2009. He had bilateral carpal tunnel releases in 2003. He has had an unspecified surgery to the feet in December 2006. Lumbar MRI was done July 21, 2010 (no official results) reported as: congenitally small central canal due to short pedicles, lumbar spine. This abnormality as well as disc disease and facet disease causes varying degrees of central canal stenosis from L2-3 through L4-5. There is prominent disc herniation at L4-5. There are varying degrees of bilateral foraminal narrowing and recess narrowing and canal stenosis as described (L2-3, L3-4, L4-5). Per the medical report dated 7/27/10, there is an extruded disc at L4-5 on the left (which is said to have been missed by the radiologist). The left L5 nerve root is compressed by the extruded disc fragment. The diagnosis includes chronic denervation potentials in the left peroneus longus and denervation potentials on the needle examination of the left low lumbar paraspinal muscles. X-ray of the lumbosacral spine, 3 views on 7/7/10 showed spondylotic and osteoarthritic changes present about the lumbar spine. Degenerative changes also present about both SI joints. The bony cortices are of normal height and alignment. There is an irregular shaped, serpiginous calcification present in the left mid abdomen of uncertain etiology. A CT is recommended to further evaluate this finding and to exclude a retained foreign body. A peer discussion did not take place as the provider is out of the office until 12/22/10. The medical report dated 12/11/10 showed persistent low back pain. There is no clear documentation of a recent comprehensive clinical evaluation that would specifically correlate with the diagnosis of lumbar radiculopathy. There is no documentation provided with regard to the failure of the patient to respond to conservative (poor copy) treatments such as an evidence-based exercise program and

medications prior to the proposed injections. The clinical information also did not provide objective documentation of the patient's clinical and functional response from the previous LESI that includes sustained an industrial injury to the pain relief, increased performance with activities of daily living or medication reduction (poor copy).

Request for reconsideration, third left LESI at L4-5 with fluoroscopic guidance; outpatient 62311, 72275 (PNR 77003), was considered in review on January 7, 2011 with recommendation for non-certification. The history is summarized. The patient was provided LESI at L4-5 on August 11, 2010; his pain improved for several days but then recurred. With a second LESI of September 29, 2010 his pain also improved for several days but then recurred. A peer discussion was attempted but not realized. [Third page of this review is lacking].

Request was made for an IRO.

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

ODG: Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. 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.

MRI is significant for, a prominent disc herniation at L4-5 (disc material extends caudally at both the right paracentral canal and left paracentral regions). CT showed mild central and lateral spinal stenosis at L4-5. Nerve studies show possible left L5 radiculopathy. Clinically, there is absent left Achilles reflex and weakness with dorsiflexion. There are sufficient indications to support left radiculopathy. However, the patient's response to both the first and second LESI has been insufficient to support repeat procedures. Six days after the initial injection the provider reports his back pain persists, but his leg pain has cleared. There is no duration noted indicating 50% pain relief for 4-6 weeks per guideline criteria for repeat injections. Following the second injection on September 29, 2010 there is no follow up assessment to indicate amount and duration of response. The nursing note of December 14, 2010 states only his left leg is still weak and it is hard for him to lift his left leg. Repeated corticosteroid injections in the context of a diabetic patient is problematic. Additionally, fentanyl, a powerful synthetic opioid, was injection also at the time of the Depomedrol injections. The patient would not be a candidate for a third LESI.

Therefore, my recommendation is to agree with the previous non-certification for a third left LESI at L4-5 with fluoroscopic guidance, outpatient 62311, 72275 (PNR 77003).

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 12-15-2010 Pain Chapter: Lumbar epidural steroid injections:

Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. [NOTE: This treatment for Low back & Neck pain is primarily covered in those respective chapters.] Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. 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.

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 by physical examination and 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) for guidance.
- 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)
- 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.
- 9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block.