

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: December 22, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

96372 Therapeutic Injection, 1 Unit; DOS: 6/30/10
J1885 Ketorolac Trimethamine Injection, 2 Units; DOS: 6/30/10
J2360 Orphenadrine Injection, 1 Unit; DOS: 6/30/10

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

This physician is a physical medicine and rehabilitation specialist with 14 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 on xx/xx/xx the claimant injured her low back while handling-lifting material.

On August 1, 2007, D.C. evaluated the claimant. Physical examination revealed muscle spasm tenderness and swelling in the low back region. ROM is restricted in all movement. Plan: Electrical muscle stimulation, ultra sound, and therapeutic mineral hot packs.

On August 5, 2007, X-rays of the lumbar spine were taken, read by M.D. Impression: Negative for acute injury.

On August 7, 2007, P.A-C evaluated the claimant. Physical Examination: Lumbar: moderate tenderness noted to mid line and diffusely along bilateral paravertebral muscles at L4-L5. No SI notch tenderness. SLR: negative. DTRs: 2+ bilaterally in lower extremities. Diagnosis: Lumbar sprain.

On August 9, 2007, the claimant started physical therapy at.

On September 26, 2007, M.D. evaluated the claimant. Noted loss of motion and soreness. Diagnosis: Lumbar strain. Medications: Flexeril 10 MG and Naprosyn 500MG.

On October 1, 2007, M.D. evaluated the claimant. Diagnosis: Lumbar sprain. Medications: Darvocet-N 100-650 MG, Flexeril 10MG, Naprosyn 500 MG, and Vicoprofen 7.5-200 MG.

On October 1, 2007, MRI of the lumbar spine was preformed, read by M.D. Impression: At L3-L4 there is early disc degeneration as well as a small posterior right paracentral radial annular tear. There is a 3x4 mm posterior focal central disc protrusion without extrusion and without evidence of involvement of the respective exiting right or left nerve root of L4. At the L4-L5 level, there is also early disc degeneration as well as a posterior central, right paracentral radial annular tear. There is at least an 8x5 mm posterior focal central, right paracentral disc protrusion without extrusion and impress upon the respective thecal sac, abutting against the exiting right nerve root of L5. There is minimal degree of central spinal canal stenosis due to the above changes.

On October 8, 2007, M.D. evaluated the claimant. Diagnosis: Spinal stenosis of lumbar region and lumbar sprain.

On October 24, 2007, M.D., an orthopedic surgeon, performed a peer review on the claimant. Opinion: The claimant sustained a self-limiting soft tissue injury to the lumbar spine.

On January 9, 2008, M.D. released the claimant to full duty.

On January 16, 2008, M.D. evaluated the claimant. Physical Examination: Spinal palpation, pain, loss of motion, stiffness/soreness, and tenderness. Diagnosis: Neuralgia, neuritis, and radiculitis. Lumbar sprain. Spinal Stenosis of lumbar region.

On January 18, 2008, M.D. placed the claimant on light duty with restrictions.

On March 19, 2008, D.O. evaluated the claimant for MMI/IR. Dr. placed the claimant at MMI as of March 19, 2008 with a 5% whole person impairment. On examination the claimant had some muscle spasm and negative SLR bilaterally.

On August 27, 2008, M.D., a pain management physician, evaluated the claimant. Physical Examination: DTRs were 2+ bilaterally. Motor examination was 5/5 bilaterally. Right SLR was positive. Left SKR was negative. Impression: Right L4-5 HNP with nerve root compression. Right radiculopathy.

On September 24, 2008, M.D., a pain management physician, evaluated the claimant. No lumbar examination was noted. Impression: L4-5 HNP and Radiculopathy pain. Plan: Pending ESI. Medications: Lortab 10mg.

On April 30, 2009, M.D., a pain management physician, evaluated the claimant. No lumbar examination was noted. Dr. noted that on February 19, 2009 the claimant underwent a right ESI at L4-5, but the claimant noted no real relief after injection. Impression: Back pain. Lumbosacral radiculitis. L4-5 HNP. Radicular pain. Plan: Refilled Lortab 10/500, Lyrica 50 MG, Ambien CR 12.5 MG, and Flexeril 10 Mg. IM Injections of Toradol 30 mg and Norflex 60 mg today for exacerbation of pain.

On June 25, 2009, M.D., a pain management physician, evaluated the claimant. Examination: Lumbar: Without CVA tenderness, forward flexion negative, extension negative, right lateral flexion negative, SI joint tenderness not present, trigger points not present. Muscle tone normal in lower extremities. Motor Strength 5/5 bilaterally. Right SLR positive. Left SLR negative. Decreased sensation at right L4, L5, and S1. Assessment: Back pain. Lumbosacral radiculopathy. Displacement of lumbar intervertebral disc without myelopathy.

On July 30, 2009, M.D., a pain management physician, evaluated the claimant. No lumbar examination was noted. Assessment: Back pain. Lumbosacral radiculopathy. Displacement of lumbar intervertebral disc without myelopathy.

On August 20, 2009, M.D., a pain management physician, evaluated the claimant. No lumbar examination was noted. Assessment: Back pain. Lumbosacral radiculopathy. Displacement of lumbar intervertebral disc without myelopathy.

On August 26, 2009, MRI of the lumbar spine was performed, read by M.D. Impression: Very mild degenerative disc changes at L2-3 and L3-4 in the lumbar spine. No other significant abnormalities seen.

On November 9, 2009, M.D., an orthopedic surgeon, evaluated the claimant. Physical Examination: Positive right SLR at 30 degrees supine and 60 degrees sitting. Right sciatic notch tenderness. No intrinsic atrophy noted. DTR are intact and bilaterally symmetrical at the knees and ankles. Decreased sensation at L5 dermatome in the right lower extremity. The claimant has some weakness of the right EHL, anterior tibialis muscles, and right extensor digitorum brevis muscle. Impression: Disc protrusion with annular tear at L4-5 and L3-4.

On November 12, 2009, NP, evaluated the claimant. No lumbar examination was noted. Assessment: Back pain. Lumbosacral radiculopathy. Displacement of lumbar intervertebral disc without myelopathy.

On December 15, 2009, D.C. performed a FCE on the claimant. The claimant is incapable of work at a Light PDL.

On February 4, 2010, D.C. performed a FCE on the claimant. The claimant appears to be getting worse. Her functional ability is less than it was on December 15, 2009.

On March 9, 2010, April 7, 2010, May 5, 2010, June 2, 2010, June 30, 2010, and July 28, 2010 NP with Dr. performed follow-up examinations.

On August 18, 2010, M.D. performed a utilization review on the claimant. Rationale: The injection provided is an intramuscular injection for acute pain that is usually given in the ER. There was no need for this injection since the claimant's complaints and symptoms are chronic and the claimant is already taking oral opiates for analgesia.

On September 28, 2010, M.D. performed a utilization review on the claimant. Rationale: The claimant has apparently been getting this same injection on a regular basis for nearly a year. There is no indication that the prior injections provided any significant lasting benefit. ODG guidelines do not recommend chronic use of muscle relaxants. More, importantly, Toradol is contraindicated in claimant's who are currently receiving NSAID's. The claimant is also reported to be taking Celebrex. The reviewed injection is not justified and is, in fact, contraindicated.

PATIENT CLINICAL HISTORY:

The claimant was injured on xx/xx/xx while lifting boxes at work. Current Medications: MiraLax 17 grams in 8oz, Biofreeze, Nexium, Celebrex, Flexeril

10mg, Ambien 10 mg, Lortab 10-500mg, Lyrica 50 mg, and Pristiq 50 mg. The claimant underwent 14 documented sessions of physical therapy.

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

The previous decisions are upheld. There is no medical documentation that the injections provided any significant lasting benefit to the claimant. Furthermore, the ODG guidelines do not recommend chronic use of muscle relaxants.

Per the ODG Guidelines:

NSAIDs (non-steroidal anti-inflammatory drugs)

Specific recommendations:

Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. ([Chen, 2008](#)) ([Laine, 2008](#))

Back Pain - Acute low back pain & acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting to negative evidence that NSAIDs are more effective than acetaminophen for acute LBP. ([van Tulder, 2006](#)) ([Hancock, 2007](#)) For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. ([Roelofs-Cochrane, 2008](#)) The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. ([Hancock, 2007](#))

Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects

than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. ([Roelofs-Cochrane, 2008](#)) See also [Anti-inflammatory medications](#).

Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in patients with neuropathic pain. ([Namaka, 2004](#)) ([Gore, 2006](#))

See [NSAIDs, GI symptoms & cardiovascular risk](#); [NSAIDs, hypertension and renal function](#); & [Medications for acute pain](#) (analgesics). Besides the above well-documented side effects of NSAIDs, there are other less well-known effects of NSAIDs, and the use of NSAIDs has been shown to possibly delay and hamper healing in all the soft tissues, including muscles, ligaments, tendons, and cartilage. ([Maroon, 2006](#)) Revised AGS practice guidelines on the management of persistent pain (including noncancer-related pain) in the elderly recommend that patients avoid NSAIDs and consider the use of low-dose opioid therapy instead, because the risks of NSAIDs in older patients, which include increased cardiovascular risk and gastrointestinal toxicity, usually outweigh the benefits. ([AGS, 2009](#))

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)**