

AccuReview
An Independent Review Organization
(817) 635-1824 (phone)
(817) 635-1825 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: December 15, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Injection, Anesthetic Agent And/Or Steroid, Transforaminal Epidural; Lumbar Or Sacral, Single Level

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/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 February 17, 2010, an MRI of the right knee revealed large bone infarcts of the proximal tibial region, distal femoral condyle, and both femoral condyles

without collapse. There is a grade I patellar chondromalacia and mild patellar femoral arthrosis. There is a grade II trochlear chondromalacia. No partial tear of the ACL was noted. PCL, MCL, and lateral collaterals all intact.

An electrodiagnostic study (date unknown) was performed. It showed reduced amplitude of the peroneal nerves bilaterally, right sural nerve mononeuropathy was also shown.

On May 10, 2010, the M.D. performed a pain clinic consultation. She had complaints of right knee pain. She has severe pain, burning sensation on the medial aspect of her knee with numbness at the right great toe, and the right lateral tibial region. She feels weakness in her legs, stating she is unable to bend or flex her knee. She has been in a brace since February, and using a crutch to ambulate. She has been on Neurontin 800 mg twice a day for two weeks which helped with muscle spasm and Soma and Flexeril without any improvement. Dr. an orthopedic surgeon does not want to operate until her nerve electrical sensations have resolved. She has tried physical therapy, however, could no continue. She has had two cortisone injections which only have her 1 day of pain relief.

On August 31, 2010, an MRI of the lumbar spine was performed. Impression: 1. L1-L2, L2-L3, L3-L4, and L5-S1: No disc herniation, canal stenosis, or neural foraminal encroachment. 2. L4-L5: Broad 1 mm disc protrusion with a 2 mm left posterolateral component. The left posterolateral portion of the disc protrusion demonstrates a zone of hypersensitivity, suggesting it is acutely irritated and t edematous.

On October 13, 2010, the claimant was re-evaluated by M.D. She has continued right knee pain. She states that workers' compensation will not proceed with surgery on the right knee until her back issues are addressed and her shooting dysesthesias are address. Dr. recommended an Epidural Steroid Injection at L4-L5.

On November 2, 2010, M.D., an orthopedist, performed a utilization review on the claimant. Rational for Denial: The provider does not address how a 2 mm left sided protrusion could cause the patient's right sided symptoms. The third page of the pain clinic note is missing. There is no imaging finding to support right sided radiculopathy. EMG was negative for radiculopathy. There was no reflex, motor or sensory deficit in the might lower extremity. Therefore, it is not certified.

On November 22, 2010, M.D., a pain management physician, performed a utilization review on the claimant. Rational for Denial: Although the claimant has some symptoms suggestive of radiculopathy, there are no objective, physical or electrodiagnostic findings of radiculopathy. The small left sided disc protrusion

on the MRI would not seem to explain right sided pain. Therefore, it is not certified.

PATIENT CLINICAL HISTORY:

The claimant is female who sustained an injury to the right knee and lumbar spine in xx/xx when she slipped while getting into a car during an ice storm.

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

The difficulty in addressing knee pain is complicated because of the addition of the disc protrusion at L4-L5. However, the small disc herniation with definite irritation of the left posteriorlateral portion of the disc should be associated with left lower extremity pain and other signs and symptoms, rather than right knee pain. From the chart one sees only that the claimant complains of pain in the right knee, with associated right sided symptoms. There is no objective evidence that the small left-sided disc protrusion causes her painful right knee symptoms. There appears to be sufficient pathology in the right knee to explain her symptoms, without invoking the lumbar disc disease as the problem producing pain on the contralateral side.

Therefore the adverse determination is upheld. There is not significant evidence that a lumbar epidural steroid injection would help her right knee pain.

Per 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)**