

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

Notice of Independent Review Decision

DATE OF REVIEW: JUNE 28, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Epidural Steroid Injection at Bilateral L5-S1 with Fluoroscopic Guidance, Epidurography and Lysis of Adhesions between 5/31/2011 and 7/30/2011.

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

This physician is a Board Certified Orthopedic Surgeon with over 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 October 12, 2009 MRI of the lumbar spine without contrast revealed: A) There is a transitional lumbosacral vertebra which is partially sacralized, therefore, this is being considered as the S1 vertebra. B) At L5-S1, there is mild grade I anterolisthesis of L5 in relation to S1, which is a pseudospondylolisthesis,

since no pars defect or spondylolysis is seen. Posterior bulging disc is present, as well as hypertrophic changes in the facet joints. The findings at this level are combining to cause moderate to marked foraminal stenosis bilaterally. Interpreted by, MD.

On October 26, 2009, the claimant was evaluated by MD who diagnosed cervical spine sprain, lumbosacral spine sprain, sprain of left hip, and sprain of left shoulder. Physical examination revealed mild to moderate tenderness to palpation in the lumbosacral spine. Painful range of motion and slightly decreased in all directions. The claimant was able to perform toe-heel-walk, walking-on-heels, and walking-on-tiptoes with moderate difficulty. Straight leg raises were negative bilaterally. Patellar and ankle reflexes were present. Neurosensory was grossly intact. He was given prescriptions for Hydrocodone 5/500 mg, Ultram ER 300 mg, Mobic 7.5 mg, and Zanaflex 4 mg.

On January 4, 2010, the claimant was evaluated by MD who diagnosed protrusion and disk herniation of C3-4, C4-5, and C6-7, Grade I anterolisthesis of L5-S1 with foraminal stenosis bilaterally, internal derangement of the left shoulder, and internal derangement of the left hip. Physical examination revealed patellar and Achilles reflexes blunt bilaterally. Motor strength decreased in his lower extremities, mostly due to back pain. His sensation was intact bilaterally. He had tenderness in his lower lumbar region and decreased range of motion with flexion and extension limited by pain. Straight leg raise elicits back pain only. Dr. recommended an EMG study of the lower extremities.

On February 25, 2010, the claimant was re-evaluated by, MD who found no change on physical examination. He again recommended an EMG of the lower extremities.

On April 1, 2010, the claimant was evaluated by, MD, a designated doctor. Dr. opined that he had not obtained maximal medical improvement.

On June 21, 2010, the claimant was evaluated by , a designated doctor, to determine the extent of his injury. Dr. opined that the extent of injury included cervical strain, resolving, low back strain and contusion of the left hip, resolving, and a complete rotator cuff tear of the left shoulder.

On July 12, 2010, the claimant was re-evaluated by MD who found on physical examination, tenderness in his lower lumbar region and decreased range of motion with flexion and extension limited by pain. Straight leg raise elicits back pain only. His motor strength and sensation were intact in his lower extremities and his reflexes were 2+ and symmetric.

On August 23, 2010, the claimant was re-evaluated by MD who found no change on physical examination.

On February 3, 2011, the claimant was re-evaluated by, MD who decided to proceed with a left shoulder arthroscopy to address his rotator cuff tear. He

spoke to the claimant about ESI following his recovery from his left shoulder. He continued the claimant on his medications as prescribed by his treating doctor.

On April 13, 2011, the claimant underwent surgery: Arthroscopic glenohumeral debridement of rotator cuff tear and superior labral tear with exam under anesthesia; arthroscopic repair of grade II SLAP superior labral tear using Arthrex PushLock; and repair of chronic rotator cuff tendon tear of greater than a centimeter in size, using three sutures anchors in a double-row repair and subacromial decompression. **Preoperative diagnosis:** Internal derangement, left shoulder. **Postoperative diagnoses:** Impingement, left shoulder, rotator cuff tear, left shoulder, and superior labral grade II tear. The claimant underwent Chest PA and Lateral Exam read by MD. The impression was no acute radiographic abnormality.

On April 18, 2011, the claimant was re-examined, MD who started the claimant off on an aggressive postoperative physical therapy program with his treating physician. He discussed options regarding the claimant's cervical and lumbar spine that included cervical and lumbar ESIs.

On May 19, 2011, the claimant was re-examined MD who recommended additional physical therapy with Dr.. Dr. gave the claimant handouts on various home exercises and stretching to help with is ROM and strengthening due to the fact that the claimant was in danger of being a candidate for manipulation under anesthesia due to his limited ROM. Dr. noted that after review the claimant's MRI, he has spondyloisthesis with disc bulging present at L5-S1 level. Physical examination revealed radiculitis of his left lower extremity.

May 27, 2011, there is an UR determination letter from. Based on the clinical information submitted for review and using the evidence-based, peer reviewed guidelines, this request for one lumbar epidural steroid injection at bilateral L5-S1 with fluoroscopic guidance, epidurography and lysis of adhesion is non certified. Rational was that the medical recorded dated 5/19/11 showed persistent low back pain. Current physical examination revealed tenderness at the mid to lower lumbar region with decreased range of motion to flexion and extension. There is positive Straight Leg Raise test on the left. There is decreased motor strength on extensor hallucis longus on the left with mild paresthesias in the lateral aspects of both lower extremities into his feet. There is no documentation provided with regard to the failure of the (patient) claimant to respond to conservative measures such as evidence-based exercise program and medications prior to the proposed epidural steroid injection. The (patient) claimant underwent 6 PT sessions with 40% improvement in pain scores and standing tolerance and would benefit from additional sessions. Therefore lower levels of care have not been maximized. Also the official results of recent imaging studies of the lumbar spine were not submitted in the review.

June 7, 2011, there is an UR determination letter from. Based on the clinical information submitted for review and using the evidence-based, peer reviewed guidelines, this appeal for the request for one

lumbar epidural steroid injection at bilateral L5-S1 with fluoroscopic guidance, epidurography and lysis of adhesion is not certified. Rationale was that there is no objective documentation provided with regard to the failure of the patient (claimant) to respond to conservative measures such as oral pharmacotherapy and physical therapy. Based on submitted records, the patient (claimant) has attended only two weeks of PT. The presence of radiculopathy is not validated by any electrodiagnostic studies. Per reference guidelines, adhesiolysis is not recommended due to lack of sufficient literature evidence.

PATIENT CLINICAL HISTORY:

The claimant was injured during a MVA.

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

The previous decisions are overturned. There is documentation of a positive Straight Leg Raise test on the left, with decreased motor strength, and mild paresthesias in the lateral aspects of both lower extremities into his feet. Also, the claimant has been unresponsive to conservative treatment. Based on the ODG the claimant meets the criteria for ESIs; therefore, the previous decisions are overturned.

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. 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)