

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: JULY 28, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpt Bilateral Lumbar Transforaminal ESI L5 64483 62311

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 Physician 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

On June 27, 2005, Mr. was evaluated by MD. He stated that the Ultram sometimes makes his "foggy". He continues to have back pain with radiation into the right leg. He also has some left femur pain in the proximal lateral femoral

area. Dr. recommended a bone scan. Impression: Lumbar post laminectomy syndrome.

On September 1, 2005, Mr. was re-evaluated by, MD. He is status post bone scan (date unknown). He continues to have numbness in both legs and feet. His bone scan was normal. Dr. recommended an EMG of the lower extremities.

On October 25, 2005, Mr. was re-evaluated by M.D. He is taking methadone 5 mg q 12 hours on a regular schedule and he is tolerating this. He still has a lot of stiffness and pain in his lower extremities. The EMG dated 9/22/05 showed a mild subacute bilateral L5/S1 radiculopathy.

On March 7, 2006, Mr. was re-evaluated by, M.D. He notes he is still having back pain and bilateral leg pain, worse in the left leg. The Celebrex does not help. He is tolerating the methadone 5 mg q 12 hours and Lyrica 60 b.i.d. Dr. recommended an ESI.

On August 9, 2006, Mr. was re-evaluated by M.D. He is status post dorsal column stimulator placement on 6/19/06. He stated the second lead was causing pain up higher into his ribs and abdomen. He is doing well with the stimulator and will consider titrating him off the Methadone and Lyrica.

On September 26, 2006, Mr. was re-evaluated by M.D. His pain has improved some with the stimulator. He can walk three blocks about three times weekly.

On January 23, 2007, Mr. was re-evaluated by M.D. He is totally off Methadone and is using the dorsal column stimulator. He has difficulty ambulating without an antalgic gait.

On May 22, 2007, Mr. was re-evaluated by M.D. His dorsal stimulator program was adjusted and is helping. He is managed with Lyrica 200 mg and Robaxin 750 mg.

On January 18, 2008, Mr. was re-evaluated by, M.D. His stimulator program was adjusted and he is now feeling it in his calf. He continues with the Hepatitis C treatment which states is a challenge with the fatigue and muscle aches.

On May 29, 2008, Mr. was re-evaluated by M.D. He is having more hypersensitivity in the lower extremities and difficulty walking.

On January 19, 2009, Mr. was re-evaluated by M.D. He is still having back pain and right hip pain especially when riding in the car or changing positions.

In April 20, 2009, Mr. was re-evaluated by M.D. He complains of muscle stiffness and tightness. He stated his left lower extremity really bothers him primarily at night in which Lyrica does not help.

On July 20, 2009, Mr. was re-evaluated by, M.D. He has had a return of pain down into his left calf and increased back pain.

On June 24, 2010, Mr. was re-evaluated by M.D. The Lyrica works well for him. He is able to perform the activities of daily living and the medications allow him to participate in family activities.

On July 16, 2010, a CT of the lumbar spine was performed and interpreted by, MD. Impression: Bilateral laminectomies at L4- and L5 with bilateral posterolateral spine fusion. Bulging annulus at L3 and L4 and L5 and S1 causing only minimal deformity of the thecal sac at L3-4. Dorsal column stimulator in the right subcutaneous tissues.

On January 27, 2011, Mr. was re-evaluated by M.D. He has been having more back pain and leg pain in the left leg. Dr. recommended an ESI.

On March 7, 2011, , M.D. performed a caudal epidural steroid injection.

On April 7, 2011, Mr. was re-evaluated by M.D. He noted good relief from the ESI. The pain comes and goes.

On April 22, 2011, M.D. performed a caudal epidural steroid injection.

On June 1, 2011, Mr. was re-evaluated by M.D. He still has pain going down both legs and his toes will still curl in extension.

On June 13, 2011, M.D., an anesthesiologist, performed a utilization review on the claimant Rational for Denial: This patient had caudal epidural steroid injections on 3/7/11 and 4/22/11 and an updated L5 Transforaminal ESI. As per medical report dated 6/1/11, he still has pain going down both legs. On examination, reflexes are absent in the knees and ankles. Motor strength and sensation are normal. This request is for repeat bilateral lumbar transforaminal ESI at L5. The records submitted do not provide objective documentation regarding pain relief (VAS scores), reduction in medication use and increase in functional activities after the rendered caudal and transforaminal L5 injections. Moreover, there is no objective documentation that the procedure will be in adjunct with evidence based exercise program aimed at restoration of function. Therefore, it is not certified.

On June 28, 2011, M.D., a physical medicine/rehabilitation physician, performed a utilization review on the claimant Rational for Denial: Treatment has included caudal ESI 3/7/11 and 4/22/11 with good relief from the first, however, there is no clear documentation of pain relief of at least 50-70% pain relief for at least 6-8 weeks, decreased need for pain medications, and functional response. Therefore, it is not certified.

PATIENT CLINICAL HISTORY:

On, Mr. was working on a large water pump, which came loose; he went to get the pump and noted pain in the lower back.

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

Denial of repeat bilaterally L5 Transforaminal ESI is upheld/agreed upon. Per ODG Low Back Chapter numbers 7 and 8, submitted documents do not specify percentage/duration of pain relief from previous injections nor specify decreased need for pain medications nor specify increase in 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, 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)