CareReview™

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 29, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
1 Lumbar Transforaminal Epidural Steroid Injection at Left L5 and S1 under Fluoroscopy and Sedation between 3/15/11 and 5/14/11.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
This physician is Board Certified in Physical Medicine and Rehabilitation with over 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 February 13, 2006 there is a report from center for MRI Lumbar Spine W/WO contrast by MD. The impression states mild diffuse disc bulges seen at L3-L4 and L4-L5 levels with no significant spinal stenosis; 3-4 mm central disc protrusion at L4-L5 associated with posterior and no spinal canal stenosis evident.

On August 22, 2007 there is an Initial PT Evaluation performed. Claimant reports pain score of 3/10 at the low back and into the left hip. Claimant states prior to his recent (2 wks ago) injection he had pain all the way into the left big toe (L5). The examination states mild decrease left L5 dermatome, DTR; WNL, bilateral, mod tenderness at right lumbar, heel drop negative, SLR positive left 45 degrees, AROM: lumbar: flx: 40 degrees; LFR 18 degrees, LFR 15 degrees, EXT 5 degrees.

On December 4, 2008 there is an initial PT evaluation at clinic. The claimant states pain is 7/10 on low back down to left foot. Sex life is restricted, needs some help but manage most of personal care, can only lift very light weight, and restricted social life and does not go out as

often. The assessment states claimant's pain radiates into his left lower extremity to heel of foot, with parathesia, and numbness/tingling.

On January 31, 2011 the claimant was seen by MD, PLLC. The physical examination states: Waddell's tenderness was absent. Lower extremities: reflexes were 2+12+ and symmetrical at the patellae and Achilles. Strength was 5/5. The gastrocsoleus complexes were measured to be bilaterally equal at 33.0 cm. The examinee was noted to have a normal gait. The conclusion states there is no medical necessity for further injection management, physical therapy, surgery, durable medical equipment, work hardening, work conditioning, or chiropractic care the claimant has not shown adequate response from the previous injections to warrant further injection procedures according to the ODG.

On March 14, 2011 there is a follow up appointment note with MD. The examination states muscle stretch reflex: right knee (femoral nerve: L2,3,4) 1+, left knee (femoral nerve: L2,3,4) 1+. Right ankle tibial nerve: S1,2) 1+; left ankle(tibial nerve: S1,2) 1+; Motor strength testing all testing 5/5: right foot inversion, left foot inversion, right foot eversion, left foot eversion, right dorsiflexion of great toe, left dorsiflexion of great toe; sensory examination Left L5 subjective dysaethetic sensation, left S1 subjective dysaesthetic sensation. The assessment states: lumbar back pain, back pain NOS; lumbosacral radiculopathy; chronic pain syndrome; long term (current) use of other medications. The plan states intramuscular injection Toradol 30mg, Norflex 60 mg.

On March 15, 2011 there is a preauthorization request from NP for left L5, S1 TF ESIunder fluoro and mac anesthesia. The request states the claimants last injection was 10/10 and has had significant relief of over 50% for months (pain was down 1-2/10) and pain has slowly progressed back to 7/10 that it currently is; function was improved also with injection and finds this month able to do less as the injection is wearing off.

On March 18, 2011 there is a document to Dr which states the Lumbar Transforaminal Epidural Steroid Injection at Left L5 and S1 under Fluoroscopy and Sedation between 3/15/2011 and 5/14/2011. The document states a straight leg raise test was not documented in the records submitted. It is noted that the patient has received numerous ESI's in the past. The clinical information did not provide objective documentation of the patient's clinical and functional response from the previous ESI that includes increased performance in the activities of daily living and reduction in medication use. Furthermore, there is also no documentation of failure of an evidenced-based exercise program prior to proposed injection. There is no indication from the provider that the proposed procedure is to avoid surgical intervention in this claimant. And finally, the official reports of the previous MRIs were not provided for review. With this, the medical necessity of a transforaminal ESI is not established at this point.

On April 11, 2011 there is a letter from NP which states the designated doctor apparently quoted claimant as saying he received 30-40% decrease in pain with the injections, claimant states he told him no, more like 50-60% decrease in pain. Please note prior to the injection his pain was 6/10 on average and for 6 wks was 2/10 or below, the claimant continued to receive relief past that, but slowly progressed to the 5-7 that is has been the past 1 ½- 2 months. He has received multiple injections but has significant decreases in his pain scores and is more functional with them. He has been less able to do household chores as the pain worsens, he has no desire to increase his medications and the injections allow him to actually decrease use of the short acting oxycodone.

On April 14, 2011 there is a letter of non certification from carrier to Dr. The letter states: it has again, been determined that the requested medical treatment does not meet established criteria

for medical necessity therefore the original determination is upheld. The letter states a straight leg raise test was not documented in the records submitted. Upon review of the report, the official reports of the previous MRIs are still not provided for review. Also, there is no documentation provided with regard to the failure of the patient to respond to conservative measures such as evidence-based exercise program and medications prior to the proposed injections. Additionally, the clinical information still did not provide objective documentation of the claimant's clinical and functional response from the previous ESIs that includes increased performance in the activities of daily living and reduction in medication use. Further, there is still not indication from the provider that the proposed procedure is to avoid surgical intervention. At this point in time the medical necessity of this request is not fully established.

On April 14, 2011 there is a document to M.D. This is a reconsideration of a previous non-certification and it has again, been determined that the requested medical treatment does not meet established criteria for medical necessity therefore the original determination is upheld. The letter states a straight leg raise test was not documented in the records submitted. Upon review of the report, the official reports of the previous MRIs are still not provided for review. Also, there is no documentation provided with regard to the failure of the patient to respond to conservative measures such as evidence-based exercise program and medications prior to the proposed injections. Additionally, the clinical information still did not provide objective documentation of the claimant's clinical and functional response from the previous ESIs that includes increased performance in the activities of daily living and reduction in medication use. Further, there is still not indication from the provider that the proposed procedure is to avoid surgical intervention. At this point in time the medical necessity of this request is not fully established.

On April 25, 2011 there is a letter from NP for reconsideration, which states the original MRI is included n the current packet for reconsideration and includes PT notes, and documents that the claimant is finding it more difficult to do daily activities since the injection is wearing off and that he is requiring oxycodone 5mg more often, and the claimant feels these are keeping him from needing surgery to control his pain.

PATIENT CLINICAL HISTORY:
Hypercholesterol; hypothyroid; nose surgery r/t deviated septum; left bunionectomy; atopic dermatitis; anemia; tonsillectomy

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
The previous decisions are upheld. Per the PDG Low Back Chapter under ESI Criteria #1 there needs to be objective evidence of radiculopathy corroborated by imaging studies and/or electrodiagnostics. Submitted clinicals do not detail matter of recent symptoms, there is no documentation of provocative dural tension testing being performed and 2006 MRI finding of 3-4 mm central protrusion of L4-5 does not correlate with request of left sided ESI at L5, and S1.

Per the 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)**