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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 05/25/2011

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified) Doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Epidural Steroid Injection Thoracic (ESI) under anesthesia with fluoroscopic guidance and recovery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female employee who sustained an industrial injury to the neck and back on xx/xx/xxxx when moving a. She related a loud crunching noise and immediate pain. Co-morbid conditions include breast surgery for cancer and occasional migraines.

The patient was reevaluated on July 13, 2010. She was last seen in November 2006. She has been managed conservatively and has not required any surgery. She relates that she has been working with pain for four years. She has never been pain free since the injury. However, she largely has been able to work through it. One week prior she was opening mail at her desk and felt a twinge in her back that spread to the mid and low back. She reports a pain level of 6/10 and a feeling of stabbing between her shoulder blades. On examination, there are muscles spasms in the T5-T10 region and L3-S1 region. She has a normal neurologic exam. Assessment is lumbar spine strain/herniated nucleus pulposus, thoracic spine strain/sprain/posttraumatic myositis, strain/sprain and posttraumatic myositis of the cervical spine, trapezius area and sacroiliac joint and right lower extremity sciatica/radicular symptoms of undetermined etiology. Imaging, medications, PT with modalities and consultation for pain management are recommended.

Lumbar x-rays taken July 19, 2010 showed no acute fracture or subluxation, mild to moderate facet joint hypertrophy and mild dextroconvex curvature. Thoracic x-rays showed no acute fracture or subluxation.

Pain management consultation of August 17, 2010 notes the original injury was in xxxx. More recently, she was holding a security camera above her head and this caused her to have pain in between her shoulder blades and in her low back. She describes a lot of low back pain. She is using Flector patches, baclofen, Mobic and Dyazide. She has a history of severe peptic ulcer disease and has been treated inpatient for stomach distress. Most of her pain appears to be in the SI joints and sacro-coccygeal joint. Recommendation is for diagnostic sacroiliac joint injections.

The patient was seen by her primary provider on September 10, 2010. Apparently a Required Medical Examination was done on August 24, 2010 and muscle relaxants were not recommended. The provider disagrees with this opinion and feels the Baclofen has been useful for the patient's muscle spasms. The SI injection was also opined to be not necessary by the RME. She has been provided with an Ortho-TENS which is helping with the spasms. In regard to the thoracic region, only moderate hypertonicity was noted. She will use Lidoderm patches instead of Flector patches. Mobic and Baclofen were refilled.

Bilateral SI joint injections were provided on September 23, 2010.

The patient underwent a Designated Doctor Evaluation on October 15, 2010 (not submitted).

At reevaluation on October 22, 2010 the provider feels that the xxxx injury is a distinct and separate injury from the xxxx injury. She localizes the pain from the current injury to the mid thoracic spine and interscapular areas with some pain radiating down the back. She has noted good relief with spinalator treatments (roller table traction) in the thoracic area. She reports good benefit with the SI joint injections for the xxxx residual symptoms, but no benefit to her current complaints to the mid back. She reports a pain level of 6-7/10 at the mid back. She is 5' 6" 170 pounds (BMI 27.4). There is marked tenderness to palpation accompanied by dense palpable spasm activity over the perithoracic interscapular and parascapular musculature areas most intensely from about the T4 down to the T9 level. Recommendation is for thoracic MRI and a consultation to consider parascapular/parethoracic trigger point corticosteroid injections.

The patient was seen in pain management on November 16, 2010. With the SI joint injections, she feels better than she has in four years. She continues in PT.

Thoracic MRI performed on January 19, 2011 showed mild T4 compression fracture with maintenance of approximately 85% vertebral body height. A mixed acute and chronic component to the fracture is suspected due to the presence of both edema and fat signal intensity. There is no associated retropulsion or canal stenosis.

The MRI findings were discussed with the patient on January 28, 2011. She can continue modified work with no lifting over 10 pounds. She has been ill and has been diagnosed with a combination of bronchitis and asthma. A sinus CT scan is pending. She remains tender in the mid back region. She will consult with a spine surgeon to rule out the necessity for surgery. She will be referred for trigger point injections.

The patient was seen in pain management on March 1, 2011. On examination there were muscle spasms in the thoracic region T4-8. She has pain laterally in the paraspinal musculature and radiating about 5-6 cm laterally. Flexion and extension aggravate her symptoms. Impression is thoracic compression fracture leading to thoracic pain and thoracic myositis. Due to the edema and the radiating pain laterally recommendation is for thoracic epidural steroid injection as a trial.

Request for Epidural Steroid Injection Thoracic (ESI) was considered in review on March 4, 2011 with recommendation for non-certification. Per the reviewer the patient is a xx-year-old female who was holding a security camera above her head when she felt pain between her shoulder blades and low back. Thoracic radiographs revealed no acute fracture or subluxation. She underwent bilateral SI joint injections in September 2010. MRI of January 2011 showed mild T4 compression fracture with maintenance of approximately 85% vertebral body height; a mixed acute and chronic component to the fracture is suspected due to the presence of both edema and fat signal intensity; there is no associated retropulsion or canal stenosis. There is no large disc herniation, canal stenosis or neural foraminal encroachment at any thoracic level. Consultation dated 03/01/11 indicates the patient has been treated conservatively with medications and therapy. Medications include Flector patch, Baclofen, Mobic and Dyazide. Physical examination showed paravertebral muscle spasm of the thoracic spine and pain laterally in the paravertebral musculature and radiating about 5-6 cm laterally. Rationale for denial states, the patient's physical examination fails to establish

the presence of active radiculopathy and the submitted thoracic MRI does not support the diagnosis. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. In peer discussion, the primary provider did not know anything about the question of radiculopathy.

Appeal letter dated March 8, 2011 states the patient has pain in the mid to upper thoracic area that radiates laterally with the medial border of the scapula. Range of motion seems to increase the pain. She has bone edema at T4 on the MRI with a mild T4 compression fracture that has both an acute and chronic component to it. Guidelines state the purpose of ESI is to reduce pain and inflammation, therefore facilitating progress in more active treatment programs, and this is the current goal for this patient. Peer to peer note of March 15, 2011 states she would benefit from a steroid injection in the area to decrease edema and nerve root irritation which has been refractory to therapy and medications. The reviewer understood the reasoning but really did not feel that the ODG guidelines had been met.

Request for reconsideration Epidural Steroid Injection Thoracic (ESI) was considered in review on March 16, 2011 with recommendation for non-certification. A peer discussion was conducted with the pain management provider. Per the reviewer, the physical examination showed paravertebral muscle spasm of the thoracic spine. She has pain laterally in the paraspinal musculature and radiating about 5-6 cm laterally. Extension aggravates her pain and forward flexion does as well. The ESI was denied as the MRI showed only a 15% T4 compression fracture but no HNP or nerve impingement. The MD stated that since the MRI showed vertebral edema, he felt a steroid injection would help. Rationale for denial states, the submitted thoracic MRI report does not support the diagnosis of radiculopathy. An ESI is not a proven treatment for a mild compression fracture, which is what she has. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review either. There is also questionable evidence of radiculopathy on exam since the patient's pain radiates only to the scapula but not around the chest.

Request was made for an IRO.

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

ODG: Epidural steroid injections (ESIs), therapeutic: Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition.

Interventional pain management procedures are supported for patients with radiculopathy or facet mediated pain who are seeking to avoid a surgery and desire to engage in more aggressive physical treatments. For epidural injections, the criteria include radiculopathy supported by clinical findings such as a motor, sensation or reflex abnormality in a dermatomal pattern with corroborating nerve studies or imaging findings. There are no nerve studies cited and the thoracic MRI (mild T4 compression fracture with maintenance of approximately 85% vertebral body height; mixed acute and chronic component suspected due to the presence of both edema and fat signal intensity; no associated retropulsion or canal stenosis) does not support the diagnosis of radiculopathy. The second level denial rationale that an ESI is not a proven treatment for a mild compression fracture, also has merit. The medical records do not support the requested treatment plan.

Therefore, my recommendation is to agree with the previous non-certification for Epidural Steroid Injection Thoracic (ESI) under anesthesia with fluoroscopic guidance and recovery.

The IRO's decision is consistent with the following guidelines:

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

According to the Official Disability Guidelines 2011: Low Back and Thoracic Chapter - Epidural steroid injections (ESIs), therapeutic: Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition.

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, 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.

(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 (greater than 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 required. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of symptoms. The general consensus recommendation is for no more than 4 blocks per region per year.

(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.