

The DYLL REVIEW

We take the worry out of Peer Reviews

25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-443

Notice of Independent Review Decision

DATE OF REVIEW: 05/17/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

724.02, Spinal Stenosis-Lumbar. 724.4, Lumbosacral Neuritis NOS. 996.04 MCH
CMP AUTM MPLNT DFBRL. V45.89 Postsurgical States NEC

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies

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.

Based on review of the available medical information and documents as reviewed, the original denial for lumbar ESI is recommended to be upheld.

The basis for the preauthorization denials indicated that the *ODG* criteria were not met for a therapeutic series of epidural steroid injections. The general basis for failure to meet *ODG* criteria indicated that specific nerve roots were not identified, nor did the clinical examinations indicate a specific nerve root of involvement but rather a more general type of symptom complex. Also, in the EMG study that was done 12/27/10, it was noted that nerve conduction studies showed bilateral sural sensory mononeuropathy of uncertain etiology. Repetitive nerve stimulation was done without any evidence of alteration of response.

Needle electromyography was done with all muscles sampled found to be within normal limits with regard to motor unit activity. There was not identified any electrodiagnostic evidence of a radiculopathy. (The EMG test was performed by interpreting Physician's Link, a telemedicine form of electrodiagnostic testing

The DYLL REVIEW

We take the worry out of Peer Reviews

25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-443

typically without any qualified electromyographer actually being in direct contact with the patient and all testing done by imaging remote direction.)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The patient, according to the medical information, first saw Dr. 12/06/10. It was indicated that he was dumping some trash in a dumpster when he slipped due to water being on the floor, resulting in injury to the low back. He was examined, x-rayed, and released with medication.

Subsequently, he came under the care of Dr., who obtained an MRI and started physical therapy. It was noted that the patient was determined to be a candidate for a two-level lumbar spine fusion at L3-4 and L4-5. He continued with low back pain and occasional lower extremity symptoms. Additional surgery, including lumbar laminectomy and posterior instrumental fusion at the level of L5-S1 was done 01/14/97.

He then, at the request of Dr., underwent hardware removal 10/12/99.

Subsequently, he has continued to remain symptomatic with low back pain in spite of seeing a number of medical providers and having multiple imaging studies. He has been noted on imaging to have profound stenosis at L3-4, thecal sac nerve root compression at L3-4, and had had prior recommendation for decompression at L3-4 on the left.

The patient, following this identification, came under the care of Dr., who recommended left-sided decompression at the L5-S1 level with extension of the fusion to the lumbosacral junction. The patient has undergone facet blocks as well as prior ESI therapy. He has participated in numerous therapy and rehabilitation programs.

At the time of his initial visit with Dr. a recommendation was made to undergo additional, updated x-rays, an EMG/nerve conduction study, and more recently a request for lumbar epidural steroid injections.

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

Based on review of the available medical information and documents as reviewed, the original denial for lumbar ESI is recommended to be upheld.

The basis for the preauthorization denials indicated that the *ODG* criteria were not met for a therapeutic series of epidural steroid injections. The general basis for failure to meet *ODG* criteria indicated that specific nerve roots were not identified, nor did the clinical examinations indicate a specific nerve root of involvement but rather a more general type of symptom complex. Also, in the EMG study that was done 12/27/10, it was noted that nerve conduction studies showed bilateral sural sensory mononeuropathy of uncertain etiology. Repetitive nerve stimulation was done without any evidence of alteration of response.

Needle electromyography was done with all muscles sampled found to be within normal limits with regard to motor unit activity. There was not identified any electrodiagnostic evidence of a radiculopathy. (The EMG test was performed by interpreting Physician's Link, a telemedicine form of

The DYLL REVIEW

We take the worry out of Peer Reviews

25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-443

electrodiagnostic testing typically without any qualified electromyographer actually being in direct contact with the patient and all testing done by imaging remote direction.)

As has previously been noted in the preauthorization denial rationale, the request does not meet *ODG* for therapeutic lumbar ESI. There is no specific identified root or objective finding of lumbar radiculopathy. Rather, the EMG shows no specific evidence of radiculopathy, and the clinical findings do not correlate to a specific nerve root. There is also no specific plan of follow-up treatment for the epidural steroid therapy other than the general mention that the patient would be recommended for physical therapy.

The rationale for this recommendation is based on the *ODG* for therapeutic ESI. A copy of this section of the *ODG* is attached to this report.

Epidural steroid injections (ESIs)	Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. [NOTE: This treatment for Low back & Neck pain is primarily covered in those respective chapters.] Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a “series of three” ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. See the Low Back Chapter for more information and references. The American Academy of
------------------------------------	---

The DYLL REVIEW

We take the worry out of Peer Reviews

25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-443

Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. ([Armon, 2007](#)) See also [Epidural steroid injections, "series of three"](#). Also see the [Neck and Upper Back Chapter](#).

Sedation: There is no evidence-based literature to make a firm recommendation as to sedation during an ESI. The use of sedation introduces some potential diagnostic and safety issues, making unnecessary use less than ideal. A major concern is that sedation may result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. This is of particular concern in the cervical region. ([Hodges 1999](#)) Routine use is not recommended except for patients with anxiety. The least amount of sedation for the shortest duration of effect is recommended. The general agent recommended is a benzodiazepine. ([Trentman 2008](#)) ([Kim 2007](#)) ([Cuccuzzella 2006](#)) While sedation is not recommended for facet injections (especially with opioids) because it may alter the anesthetic diagnostic response, sedation is not generally necessary for an ESI but is not contraindicated. As far as monitored anesthesia care (MAC) administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of post-op care. Supervision services provided by the operating physician are considered part of the surgical service provided.

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 by physical examination and 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) for guidance.
- 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and [functional improvement](#), including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. ([Manchikanti, 2003](#)) ([CMS, 2004](#)) ([Boswell, 2007](#))
- 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.
- 9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block.

The DYLL REVIEW

We take the worry out of Peer Reviews

25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-443

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)