



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 10-10-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

64483 injection foramen epidural L/S; 76005 Fluoroguide for spine injection; 62284 Injection for myelogram; 72100 x-ray exam of lower spine; 64484 Injection foramen epidural add; 099SG ASC Facility service DOS 9/9/11-11/4/11

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

American Board of Orthopaedic Surgery-Board Certified

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

PATIENT CLINICAL HISTORY [SUMMARY]:

4-28-10 EMG/NCS performed by MD., showed no electrical evidence of active or acute lumbar/lumbosacral radiculopathy bilaterally.

8-31-09 Transforaminal epidural steroid injection at right and left L5 performed by MD.

9-20-10 MD., the claimant is seen in follow-up. He comes today stating he is having residual symptoms into the left shoulder as well as the back. There is apparently some dispute still regarding his impairment assessment that he did. As he went through it relatively painstakingly he felt that the 6% was the appropriate impairment for him. At this point though, he is still pending apparently another impairment assessment independent of his. He is trying to work. We had him still doing regular duty. However, obviously anything that would be required overhead on a prolonged basis is not going to be well tolerated given his left shoulder symptoms and the heavier lifting regarding his back. His medication regimen has included that of the Darvocet and Ambien. He is not reporting any side effects except that sometimes he gets some mild nausea with the pain medication but he states that is not unusual for him with pain medication. On exam, he still has decreased shoulder ROM on the left. He does have on SLR pulling into the low back and towards the calf on the left side. There is some mild swelling of his legs. He had suggested to him that if he is going to do prolonged standing that some type of support hose may be helpful in that regard although that is not a specific work injury incident. Plan: he was going to see the patient back in four months or earlier if

his symptoms are progressive. He can come in earlier if he has residual or increasing symptoms or problems. He will keep him on the regular duty.

12-20-10 MD., the claimant is seen in follow-up. He comes today stating he is trying to increase his walking activity. He has obviously had several surgeries that have interfered with that over this past year. He does need some other medication for the Darvocet which he had used. The surgery is less symptomatic. He is doing basically regular duty. He does have symptoms that sound as if he is getting progression of his neurological symptoms into the lower extremity though with prolonged standing or walking as he stated he was in a concert/cantata yesterday and after standing for that he had to actually sit down and after about ten minutes so it started feeling better. This actually radiates into his legs. On exam, the shoulder ROM is only mildly decreased on the left, He does have end range discomfort, mild impingement arc but no significant weakness there. The lumbar spine as long as he does not have to stand or walk for any prolonged distance he appears to tolerate fairly well. He has some tightness into the back and into the leg but nothing of a specific dermatome that he can determine today. He did not measure calf circumference. Plan at this point is medication management but he did talk with him about proceeding with some type of imaging study of the lumbar spine if these symptoms persist or increase. He was going to let him continue with regular duty at the present time recognizing that he has intrinsic restrictions at the plant.

3-21-11 MD., the claimant is seen in follow-up for his lumbar disorder. He states the shoulder is feeling better. His pain has increased. He has had to do a little bit more work at the facility as well. He felt that has kind of given him a temporary. Hopefully this is not a permanent one. We talked over the use of medication management in his situation. He is working regular duty. He was hesitant to add a strong anti-inflammatory, such as a Medrol Dosepak given the swelling that he is having in his legs and lower portion. He has pitting edema. He states that he is going to be checking in with his internist as well. He has the spondylolisthesis of L5 on S1, obviously this can contribute to his low back pain. He points to the left low back as being a particular area of soreness. On exam, there is tightness in his legs distally from some of the swelling. He has pitting edema to the mid tibia. SLR causes pulling sensation but no radicular pattern. Reflexes are decreased at the knee and ankle but not asymmetrically. His plan then is to provide medication support and Tramadol was written as well as Ambien. He is going to take half the dose on the Ambien. He will see him back approximately in three months or earlier if his progression of symptoms does not decrease. He would be a potential candidate for further injection treatment but obviously he needs to get control of any type of blood pressure issues or the basis for the swelling before he even considers that regimen.

7-18-11 MD., the claimant is seen in follow-up. He comes today stating that he is still working regular duty but he has episodes where he has increased pain after doing too much. It is in his back and goes down into his buttock area. He states for example the other night he took Tramadol as well as a sleeping pill and even ended up taking a muscle relaxant that he had from a previous prescription. None of this was effective in helping him sleep. He states sometimes he just needs something more, especially if he

over does. Based on this and his allergy to codeine, he did concede to write for a few Hydrocodone. He is to utilize these sparingly. On exam, SLR does not reproduce any particular radicular pattern. However, on the left side he does report that it is "tender". We have known that in the past and that is relatively unchanged. Plan of care is going to modify his medication management to adjust and help him with sleep deprivation. He is to continue regular duty and he will see him back here in approximately three months. If this is still inadequate he would propose that we consider getting a new imaging study to assess what has changed and what is the basis for this breakthrough pain that is interfering with sleep.

8-1-11 MD., the claimant is seen in follow-up. He presents today stating that he had a flare of his symptoms. He was actually going into a room and he tripped over some wrapping. It jarred his back. He has had problems with radiating pain before but it seems to have increased and he is asking what we can do about this to try to help get his symptoms back under control. He has been utilizing medications. He is still trying to do regular duty. He states that he has same accommodation provided him by his supervisor for this back issue. On exam, SLR is distinctly positive on the left all the way down to the calf. He has numbness on the top of his foot in the great toe distribution, an L5 type scenario. The right side is not involved. He has had good benefit with the previous transforaminal ESIs. Plan: He would propose that he actually do a double here so to speak, a transforaminal at L5 on the left as he does have spurring and it may make it difficult to access there but also then a caudal ESI to give wider spread as he does have symptoms although not near as severe towards the right side, He will submit him for that through workers comp. He is quite claustrophobic and thus he will hold off doing the MRI. If he does not get adequate benefit out of the ESI then he will need further diagnostics done as well.

8-9-11 Utilization Review performed by DO., notes the claimant is a xx year-old injured individual with complaints of low back pain following lifting injury network occurring on 8/04/08. Claimant developed left-sided sciatica. Imaging studies are reported to show L5-S1 spondylolisthesis with L5 spondylosis. Claimant is working regular duty with episodes of back pain going down to the buttock area. Physical exam shows no radicular pattern with straight leg raise. There is tenderness at left side. Case management note the claimant has had lumbar epidural steroid injection on 5/11/09 and 7/21/11. The record reports claimant had prior epidural steroid injections with symptoms resolving in the past. Based upon the available medical documentation and current clinical guidelines, without significant improvement in functional activities and significant pain reduction with first epidural steroid injection and without unequivocal evidence of radiculopathy, the requested transforaminal lumbar epidural steroid injection is not considered to be reasonable or medically necessary.

9-9-11 Utilization Review performed by MD., notes verbal non-certification per PA review for Transforaminal lumbar epidural steroid injection given to Karla, surgery coordinator/Dr. Recommendation: Non-certify request for transforaminal lumbar epidural steroid injection. Pertinent clinical information / Rationale: This xx year old IW with date of onset xx/xx/xx complains of low back pain following lifting injury associated with left-

sided sciatica. Imaging reports L5-S1 spondylolisthesis. The claimant is working regular duty with episodic back pain. Physical exam shows no radicular pattern with straight leg raise. Epidural steroid injections were carried out 05/11/09 and 07/21/09, which were apparently helpful, but this is not quantified. Guidelines indicate that relief should last for at least 6 weeks and reduce pain by at least 50%. Request is not considered reasonable or medically necessary without quantification of the benefits provided by prior injections.

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

The medical records reflect a history of spondylolisthesis at L5/S1 with L5 spondylosis. Claimant had prior ESI with alleged benefit but not quantified. The benefit from the injections did not note increased clinical function or reduction of pain on a long term basis. Claimant has not been found to have objective neurological changes. Therefore, the request for 64483 injection foramen epidural L/S; 76005 Fluoroguide for spine injection; 62284 Injection for myelogram; 72100 x-ray exam of lower spine; 64484 Injection foramen epidural add; 099SG ASC Facility service for DOS 9/9/11-11/4/11 is not reasonable or medically necessary.

ODG-TWC, last update 9-21-11 Occupational Disorders of the Low Back – Lumbar epidural steroid injection:

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)**