



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 4-5-12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar transforaminal epidural steroid injection right L4-L5

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

American Board of Anesthesiology and Pain Medicine

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

- 6-20-11 MD., office visit.
- 6-20-11 MD., performed a Treating Doctor Evaluation.
- 12-29-11 MD., office visit.
- 1-20-12 MD., office visit.
- 2-17-12 MD., office visit.
- 2-24-12 UR performed by MD.
- 2-29-12 MD., performed a UR.
- 3-8-12 MD., office visit.
- 3-8-12 UDS.
- 3-15-12 MD., office visit.

PATIENT CLINICAL HISTORY [SUMMARY]:

6-20-11 MD., the claimant was seen for followup. He says he took some time off last week and rested his back. He did some stretches and is now 80-85% of normal. He says he is ready to return to full function. On exam, he has full range of motion, no spinous tenderness, no paraspinous tenderness. Assessment: Lumbar sprain. Plan: Release to full duty, continue NSAIDs, continue stretching. No follow up.

6-20-11 MD., performed a Treating Doctor Evaluation. She certified the claimant had reached MMI on this date and awarded the claimant no permanent impairment.

12-29-11 MD., the claimant continues with constant lumbar pain but this was tolerable, 2 months ago, he reached across to help make the bed and had worsening of his back

pain. The pain continued to progress and is causing him difficulty getting in or out of a car. He is not having radiating down his right buttocks and leg. When seen by a chiropractor he had no significant improvement. He has tried Biofreeze, heat, massage, and stretching. On exam, the claimant has 2+ bilateral ankle reflexes, 3+ right knee and 2+ left knee reflexes. No clonus. He is able to fully raise bilateral legs, but does have radiation of pain with raising the leg. Assessment: Lumbar strain with radiculopathy. Records requested from Dr.. The claimant was referred to physical therapy and an MRI was requested. Recommendations for a trial of oral prednisone, Vicodin prn, Ibuprofen 800 MG. Return to work full status.

1-20-12 MD., the claimant reports his pain is 3/10 today. Pain is worse in the AM. PT did not get scheduled. Patient states that he did get 3 ESI treatments by Dr. despite the lack of records in the system. Patient is able to reach to toes. He is able to side bend and twist. He is tender to his right SI area. MRI - herniated disc. Assessment: Lumbar sprain with radiculopathy. Plan: Refer for ESI. Request PT. The claimant was returned to work without restrictions.

2-17-12 MD., the claimant had his first physical therapy appointment. He is requesting refill on Vicodin. The tingling has improved slightly but the back pain is worse. On exam, he is able to reach to ankles. Side bend and twisting are normal. Assessment: Lumbar sprain. Plan: Medications refill. The claimant will be seen as needed after he sees pain management.

2-24-12 UR performed by MD., notes the claimant is a who had a lifting incident at work with subsequent low back pain and buttock pain. The neurological exam only showed a reported sensory deficit of the right L4 but otherwise there were no objective changes reported. The official MRI report was not forwarded. The request does not meet the ODG criteria as there is lack of an objective neurological deficit that correlates with the MRI. Further validation is needed.

2-29-12 MD., calls were made. On 2-29-12 call was made and left a message. On 3-5-12 a call was made and LVM. The patient is a male whose date of injury is xx/xx/xx. MRI of the lumbar spine dated 01/16/12 revealed moderately large central disc protrusion/herniation at L4-5 which extends slightly below the level of the interspace. This creates a moderate anterior extradural defect upon the thecal sac with slight decrease in the diameter of the thecal sac. Follow up note dated 02/20/12 indicates that the location of the pain is primarily in the lower lumbar spine. The patient is currently undergoing physical therapy twice weekly. On physical examination straight leg raising is negative bilaterally. Muscle strength is normal in the lower extremities. There is decreased sensation to the right L4 dermatome. Based on the clinical information provided, the request for lumbar transforaminal epidural steroid injection right L4-5 is not recommended as medically necessary. The patient's physical examination fails to establish the presence of active lumbar radiculopathy. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review.

3-8-12 MD., the claimant is a male seen of followup. He presents with primary complaint of back pain. The claimant reports his pain radiates to the lateral leg to the bottom of the right foot. He also reports tingling in the right ankle/foot. On exam, he has positive right SLR to 45 degrees. Paresthesia at rest, lateral aspect of the right ankle. Assessment: Herniated lumbar disc, myofascial pain syndrome. Plan: The evaluator reported the claimant is suffering range of motion a herniated disc that is causing him considerable pain. The evaluator recommended a series of epidural steroid injections in hopes of having him continue at his current job. He is taking medications, but does not feel it is managing his pain and may need to take off work as he is concerned that safety is an issue due to amount of pain he is in. The evaluator was going to take over his medications as follows: Vicodin 5/500 and Motrin 800 mg. UDS to be done in the office today.

3-8-12 UDS was positive for opioids.

3-15-12 MD., the claimant is to have epidural steroid injection but then it was cancelled due to lack of approval. His is not missing work due to the severity of the pain. He is no longer able to get in/out of patrol cars without pain. The claimant is awaiting approval for the epidural steroid injection. Medications per Dr.: Ibuprofen and Vicodin 5/500. The claimant is returned to work with restrictions.

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

THE CLAIMANT WAS RE-EVALUATED AFTER THE DENIAL AND WAS DOCUMENTED TO HAVE POSITIVE STRAIGHT LEG RAISES AT 45 DEGREES ON THE RIGHT LEG. HE ALSO HAS SENSORY LOSS AND A MRI SHOWING A DISC HERNIATION AT L4-5. HE HAS FAILED REASONABLE CONSERVATIVE MEASURES. BASED ON THE RECORDS PROVIDED, A LUMBAR TRANSFORAMINAL EPIDURAL STEROID INJECTION RIGHT L4-L5 WOULD BE REASONABLE AND MEDICALLY NECESSARY.

ODG-TWC, last update 2-20-12 Occupational Disorders of the Low Back – 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)