

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: August 1, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

77003 – Fluoroguide for spine inject, A4550 – Surgical trays, A4649 – Surgical supplies, 99144 – MOD CS by same phys, 5 yrs+, 99145 – MOD CS by same phys add-on, 62311 – Injection spine L/S (CD), 72275 – Epidurography (Repeat Lumbar Epidural Steroid Injection)

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

This physician is a Board Certified Physical Medicine and Rehabilitation physician with over 16 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

03/30/11: Required Medical Exam by DO
11/29/11: Follow Up Examination by MD with Pain Institute
01/10/12: Follow Up Examination by MD with Pain Institute
02/14/12: Follow Up Examination by MD with Pain Institute
03/01/12: Operative Report by MD
04/03/12: Follow Up Examination by MD with Pain Institute
04/10/12: Follow Up Examination by MD with Pain Institute
04/18/12: Operative Report by MD
05/10/12: Follow Up Examination by MD with Pain Institute
05/31/12: Follow Up Examination by MD with Pain Institute
06/07/12: UR performed by MD
06/19/12: Follow Up Examination by MD with Pain Institute

06/29/12: UR performed by MD

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx when he was involved in an altercation with a coworker. The claimant attempted to run away and tripped sustaining injuries to her right knee and later developed pain in his low back and numbness and tingling of the right foot. Dr. operated on his right foot and he subsequently developed symptoms compatible with complex regional pain syndrome. In 1996, Dr. implanted a spinal cord stimulator. He has also undergone a partial medical meniscectomy and chondroplasty of the patellofemoral joint and lateral release for right knee complaints in 1198. In 1999, a discogram showed degeneration of L5-S1 and in May 2000, Dr. performed decompression L5-S1 and posterior lumbar interbody fusion and posterolateral fusion with pedicle screw fixation. In 2000, Dr. performed tarsal tunnel release and excision of ganglion on the right ankle. A myelogram in June 2011 showed evidence for arachnoiditis and in July 2002, Dr. removed implanted hardware and decompressed L4-5 and L5-S1. The spinal cord stimulator was replaced in 2003. The claimant has also been treated with a series of Hyalgan injections and sympathetic blocks.

On November 29, 2011, the claimant was re-evaluated by MD for pain in his right foot and lower back. It was reported he underwent a right lumbar sympathetic block with Phenol for the right foot and had greater than 50% relief of neuropathic symptoms. He reported an acute exacerbation of severe low back pain for which he saw Dr. who recommended a series of 2 lumbar epidural injections. On physical exam he was walking with a roller walker. He had pain with range of motion to the lumbar spine in all directions. He had tenderness to the quadratus lumborum, gluteus maximus, and gluteus medius. He had a decreased sensation to light touch down the left lower extremity at the L4-L5 distribution. Straight leg raises while sitting were +90 degrees. Diagnosis: Patient with a history of lower back pain with left sided radiculopathy with an acute exacerbation of his symptoms. Plan: He had not undergone an MRI secondary to an implantable spinal cord stimulator system for the treatment of his right foot pain. Thus, Dr. believed it was medically indicated, necessary, and reasonable that they proceed with a single lumbar interspinal injection with trigger point injections to the paraspinal muscle under fluoroscopic imaging in an effort to decrease his radicular symptoms.

On January 10, 2012, the claimant was re-evaluated by MD who reported he underwent a lumbar ESI on December 23, 2001 with 70% instant relief and at current 40% relief. Plan: Undergo a rehabilitation program 3 times a week for 4 weeks. The claimant was also given a trigger point injection with Toradol 60 mg intramuscularly.

On February 14, 2012, the claimant was re-evaluated by MD who noted he had a residual return of low back pain to a baseline of 40% following the ESI in December. On physical exam his gait was slow and guarded. His range of

motion was limited secondary to pain. He continued to have pain and numbness to the left lower extremity and the right lower extremity. He had pain across the lower back on examination. Plan: Proceeding with a series of 2 lumbar interspinal injections with trigger point injections to the paraspinal muscles under fluoroscopic imaging two weeks apart. A rehabilitation program was also recommended for 3 times a week for 3 weeks. The claimant was given a trigger point injection with Toradol 60 mg intramuscularly.

On March 1, 2012, Operative Report by MD. Postoperative Diagnosis: Low Back Pain, Myofascial Pain Syndrome. Procedures: Lumbar intraspinal myelography without dural puncture (epidurogram); Fluoroscopic guidance and interpretation; Analgesic injection, Myoneural Injection x 6 sites, Intravenous sedation.

On April 3, 2012, the claimant was re-evaluated by MD who reported the claimant's pain improved about 70% with injection therapy. The claimant was still having pain but had been able to get off the rolling walker and was using a single prong cane. On physical examination he had pain to the lumbar paraspinal muscles and gluteal region. He still had pain radiating down the right lower extremity. He had a very stiff and a significantly decreased range of motion to the lumbar spine. Plan: Additional lumbar interspinal injection with trigger point injections under fluoroscopic imaging.

On April 18, 2012, Operative Report by MD. Postoperative Diagnosis: Low Back Pain, Myofascial Pain Syndrome. Procedures: Lumbar intraspinal myelography without dural puncture (epidurogram); Fluoroscopic guidance and interpretation; Analgesic injection, Myoneural Injection x 6 sites, Intravenous sedation.

On May 10, 2012, the claimant was re-evaluated by MD who he underwent 3 epidural steroid injections with significant improvement of his symptoms, but was having more difficulty now. On physical examination he had tenderness to the paraspinal muscles and gluteal region and had a slow guarded gait pattern. Plan: He was given a trigger point injection with Toradol 60 mg intramuscularly and was encouraged to be as active as possible.

On May 31, 2012, the claimant was re-evaluated by MD who reported he had some gradual return of pain and has had more difficulty with standing that day, then in the past. On physical examination he had some decreased sensation as well as some numbness and tingling to the right lower extremity to the knee and the left lower extremity all the way down into the foot. It was primarily in the L3-L4 and L4-L5 distribution. His gait was slow guarded and he used a cane for ambulation. He had difficulty with range of motion to the lumbar spine in all directions as it caused pain. He had tenderness across the paraspinal muscles and gluteal region. Diagnosis: Patient with lower back pain and radiculitis. Plan: Undergo a lumbar intraspinal injection at the L3 level with trigger point injections to the paraspinal muscles under fluoroscopic imaging. The claimant was asked to use the spinal cord stimulator system and encouraged to be as active as possible.

*****Please note a medical record for a patient with the initials G. V. dated June 1, 2012 was included in the medical records. This note for the wrong patient indicated an ESI injection for May 22, 2012. This is the ESI cited by the previous UR physicians and should be recorded that the cited ESI on May 22, 2012 was not for Augustin Zapata.*****

On June 7, 2012, MD performed a UR. Rationale for Denial: The request for repeat lumbar epidural steroid injection #4 is non-certified. The clinical documentation submitted for review indicates the patient has undergone 3 to 4 prior lumbar epidural steroid injections, with the most recent on 05/22/12. Official Disability Guidelines recommend that patients have at least 50 to 70% pain relief for 6 to 8 weeks before repeat blocks are warranted. The patient was only approximately 1.5 weeks status post injection when he was re-evaluated on 06/01/12. Therefore, there is no indication that the patient has had at least 6 to 8 weeks of relief. Furthermore, practice guidelines recommend no more than 4 blocks per year. Given the lack of long-term relief from prior injections, the request is not supported at this time. Furthermore, there are no imaging studies submitted for review to corroborate evidence of radiculopathy in accordance with Official Disability Guidelines. In addition, the proposed level for the epidural injection was not given. As such, the request is non-certified.

On June 19, 2012, the claimant was re-evaluated by MD who reported he had done very well for about 6 weeks and for the last week he had a return of pain to the left lower extremity. The pain was moderate to severe in nature and had affected his ability to function on a daily basis. On physical examination he had a very slow guarded gait pattern. He used a cane for ambulation. He had a decreased sensation to light touch to the L3-L4 and L4-L5 distribution. He also stated that he had heaviness to the left lower extremity. His range of motion to the lumbar spine was limited in all directions with pain being reproducible with these activities. Plan: Undergo a lumbar intraspinal injection with trigger point injections to the paraspinal muscles under fluoroscopic imaging.

On June 29, 2012, MD performed a UR. Rationale for Denial: ODG notes that lumbar epidural steroid injections are supported for treatment of radicular pain. It is further noted that there must be documentation of pain relief of at least 50 -70% for at least 6-8 weeks, additional blocks may be supported. In this case the claimant underwent an epidural steroid injection on 12/23/11 with 80% benefit reported, another injection on 03/01/12 with 70% improvement reported, and significant improvement following the injection in May, with decreased use of medications. In this case considering that the most recent injection was on 05/22/12 it is not clear that an additional injection is appropriate prior to the recommended 6-8 weeks. Absent further clear and detailed documentation of any extenuating circumstances, medical necessity is not established.

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

Denial of Repeat Lumbar Epidural Steroid Injection is upheld/agreed upon. Per ODG Low Back Chapter (#7) repeat ESIs are recommended when previous ESI results in a 50-70% decrease in pain and decreased medication use and increase function. Submitted information does not detail percentage of relief of pain after the 2nd injection, nor mentions any change in medication and the duration of relief was less than the recommended 6-8 weeks (since the 2nd ESI was 4/18/12 and 2-3 weeks later on 5/10/12 follow up there was notation of “more difficulty now”). Also ODG Back Chapter #10 recommends that ESI not be performed with other injections, including trigger point injections. Since previous ESIs were given with trigger point injections, it is difficult to ascertain which procedure resulted in what benefit. Therefore the request for 77003 – Fluoroguide for spine inject, A4550 – Surgical trays, A4649 – Surgical supplies, 99144 – MOD CS by same phys, 5 yrs+, 99145 – MOD CS by same phys add-on, 62311 – Injection spine L/S (CD), 72275 – Epidurography (Repeat Lumbar Epidural Steroid Injection) is not found to be medically necessary.

Per 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)**