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Notice of Independent Review Decision

DATE: November 30, 2012; **AMENDED December 1, 2012**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L4-L5 Epidural Steroid Injection with Fluoroscopy, 54483 x 2 and 77003, Sedation 01992; **AMENDED: Right L4-L5 Epidural Steroid Injection with Fluoroscopy, 64483 x 2 and 77003, Sedation 01992**

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

The review is certified by the American Board of Anesthesiology with a secondary practice in pain management with over 40 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:

11/12/11: ER Visit
12/23/11: Office Visit
12/23/11: Initial Therapy Evaluation
01/10/12: Progress Note
01/18/12: Right Knee MRI report
01/18/12: Lumbar MRI report
01/20/12: Progress Note
02/03/12: Progress Note
02/07/12: Note
03/09/12: Progress Note
03/15/12: Referral Prescription
04/02/12: New Patient Consult
04/03/12: Visit Note
04/10/12: Progress Note
04/11/12: Followup Visit

04/20/12: Progress Note
05/11/12: Progress Note
06/04/12: Consultation
06/11/12: Progress Note
06/14/12: Right Knee Injection report
06/13/12: Notice of Disputed Issue(s) and Refusal to Pay Benefits
06/21/12: Request for Designated Doctor Examination
06/23/12: Notice of Benefit Review Conference from Texas Department of Insurance
07/02/12: Progress Note
07/17/12: Notice of Approval of Request for Designated Doctor Examination
08/06/12: Report of Medical Evaluation
08/16/12: Fax Cover Sheet
08/21/12: Progress Note
09/10/12: X-Ray Lumbar Spine report
09/10/12: Visit Note
09/12/12: UR Determination Letter from
09/12/12: Message Log
09/27/12: Visit Note
10/10/12: Letter of Medical Necessity
10/17/12: Peer Review Report
10/17/12: Utilization Review Request
10/19/12: UR Determination Letter
11/05/12: Fax Cover Sheet
11/06/12: Peer Review Report
11/06/12: Notice of Reconsideration Request Receipt
11/08/12: UR Determination Letter

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who injured her low back and right knee when she fell from a ladder at work on xx/xx/xx. She has undergone physical therapy.

11/21/11: The claimant was evaluated in the ER for back pain and hip pain after a fall. She was discharged the same day. The records are not legible.

12/23/11: The claimant was evaluated who diagnosed her with a lumbar strain and a knee sprain/strain. He recommended physical therapy and gave her prescriptions for ibuprofen and Flexeril.

12/23/11: The claimant was evaluated by PT who noted the plan of physical therapy 3 times per week for 2 weeks.

01/18/12: Right Knee MRI report. IMPRESSION: Hypermobil medial meniscus with mild osteoarthritis change of the medial compartment. Findings of abnormal patellar mechanics with mild chondromalacia patella. Prepatellar contusion or scarring. Lateral meniscal cyst.

01/18/12: Lumbar MRI report. IMPRESSION: Focal protrusion/herniation right posterolaterally at L5-S1. Mild spondylosis change at L4 through S1 with anterolisthesis L4-L5 and retrolisthesis L5-S1. Mild scoliosis. This may represent muscle spasm.

02/03/12: The claimant was. On examination, she had mild lumbar muscle spasm. ASSESSMENT: Lumbar strain. Sprain/strain knee. PLAN: Followup with ortho as scheduled. RTC on 03/09/12. Continue medications as previously prescribed. Work modifications as previously instructed.

02/07/12: The claimant was. IMPRESSION: PLAN: I injected her right knee today after sterile prep and informed consent was obtained. She tolerated this well. I would like for her to start physical therapy as soon as possible and then consider an SI joint injection to be done quickly so that she can progress with improvement. I will see her after the SI joint injection is done.

03/09/12: The claimant was reevaluated. She stated that her back pain was getting worse and she was getting occasional pain on her right lower back and pelvis down to her right leg/knee. She also stated that her left leg would become numb. Her current medications were ibuprofen as needed. On physical exam, gross exam of the lumbar spine revealed no swelling, ecchymosis, changes in spinal curvature, or other abnormalities. Her gait was normal with no evidence of limp. Lumbar ROM remained decreased to flexion/extension. Sensation was within normal limits. Palpation remained positive for pain at the sacral area and right lumbar region. Reflex testing was normal and equal bilaterally to Achilles and patellar. Straight leg raising was negative bilaterally, both seated and supine. She had normal strength to dorsi/plantar flexion of great toes. Abdominal exam demonstrated normal bowel sounds and was negative for pain to palpation. Circulatory exam was normal with equal pulses bilaterally. Waddell's tests were negative. PLAN: Patient received steroid injection in the right knee from Ortho (Garcia) last week. She is now pending authorization for an SI joint injection with Ibuprofen 800 mg t.i.d. p.r.n. pain. Limit lifting to approximately 10 lbs. Limit pushing/pulling to approximately 10 lbs. No climbing stairs or ladders. No prolonged standing/walking longer than 45 minutes. No bending more than six times per hour. Recheck in six weeks.

04/02/12: The claimant was evaluated for low back pain as well as cervical and bilateral knee pain. It was noted that she had not done physical therapy or injections for her low back pain. Her current medications were listed as ibuprofen 800 mg. ASSESSMENT: Lumbar HNP/disc displacement without myelopathy. Thor/lumbosacral neuritis/radiculitis. PLAN: A urine sample was obtained for routine monitoring. The sample was obtained under the supervision of a staff member and was appropriate in tactile assessment and inspection. The sample was labeled and sealed with the patient present. The sample will be sent for analysis. Will performed UDS today to ensure patient is compliant with our clinic's drug policy. Followup: 2 weeks, LESI right L4, L5.

04/10/12: The claimant was. Her physical exam revealed no change since previous visit on 03/09/12. There was no impression or plan documented on this note.

05/11/12: The claimant was. Again, her physical exam revealed no change since visit dated 03/09/12. PLAN: The patient has been evaluated/treated for both her right knee and lower back (ortho) with recommendation for knee arthroscopy as well as ESI for her back. Apparently the patient has been advised is not a network physician. She is therefore referred to orthopedics for her right knee. She is currently seeing regarding her lower back.

06/04/12: The claimant was evaluated for her right knee pain. On examination, she had no tenderness to palpation in the midline back. The pack appeared stable and had good range of motion with normal muscle tone. Motor testing was normal. Sensation was normal. He stated that he "wonder if there is actually a problem inside the knee or outside the knee. As there is nothing surgical, I filled out the DWC form with the same restrictions she was at. She will followup with me as necessary." There was no mention made of lumbar pathology in his impression/plan.

06/11/12: The claimant was reevaluated. It was noted that she felt her pattern of symptoms was unchanged. On physical exam, there were no changes from previous exam. PLAN: The patient was evaluated ortho spine on 04/02/12 who recommended LESI. However, the patient has not yet received this treatment and states she has not been able to establish contact with their office. Request is submitted for her to see another ortho spine specialist. She has also received an evaluation (ortho) for her right knee who recommends a knee aspiration for later this month.

06/14/12: Right knee injection. IMPRESSION: No discrete parameniscal cyst. Area of symptoms overlies the popliteal tendon sheath which had some increased fluid. This area was injected without immediate pain relief.

07/02/12: The claimant was reevaluated. Her exam was unchanged. PLAN: The patient completed a right knee aspiration on 06/14/12 as recommended further reported releasing her from care as there was no surgical lesion to be addressed. The patient is now pending authorization (2nd referral) to see ortho spine doctor as she has had difficulty establishing contact for treatment (ortho spine).

08/06/12: The claimant was evaluated to address maximal medical improvement (MMI). It was noted that she had pain that seemed to involve the entire spine, but more concentrated in the lower back area as well as pain down into the posterior sacral areas. She seemed to have more pain radiating to the right side as opposed to the left. She had pain that radiated to the side of both thighs, but occasionally some calf soreness. She had noticed no numbness or particular weakness in either extremity. She had noticed a great deal of tightness and stiffness in her back in all directions. She seemed to be better in the supine

position. She could not sit very long because of tightness in her back. It was noted that she was seen on 02/27/12 who recommended caudal epidural steroid injection as he felt that there was documented single level discogenic pathology with clinical evidence of radiculopathy. It was also noted that she had been in physical therapy since July 12 and seemed to be making some progress. On examination, she walked with a very stiff back. She had difficulty getting on and off the exam table because of tightness in her lower spine. She was able to heel and toe walk well. Examination of her lumbar spine demonstrated a "very, very stiff lower lumbar area." She was able to forward flex to touch her knees. Lateral bending and lateral rotation was only about 20-25 percent of normal motion. She had a great deal of paraspinous muscle spasm. In a sitting position, she had a negative straight leg raise and negative bowstring test. She did have some sacroiliac joint tenderness to direct palpation. Provocative sacroiliac joint tests were positive for sacroiliac joint pathology. With compression of the hips, was able to reproduce some discomfort in the sacroiliac area as well. Figure-four tests were positive bilaterally. There was no tenderness in the sciatic notch or any tenderness along the sciatic nerve. On neurological exam, she did not have any deficit in the lower extremities, and all muscle groups were strong and symmetrical. No atrophy. DTRs in the lower extremities were all normal and symmetrical. **DIAGNOSIS:** Lumbar sprain/strain with intermittent nerve irritation symptoms. Sacroiliac strain. Right knee strain with underlying patellofemoral pathology, possibly peripheral attachment of medial meniscus. After completion of a comprehensive evaluation, she was found to have not reached maximum medical improvement. She does have some primary knee pathology, but some of the knee pain that she is experiencing may be referred pain from her sacroiliac joint or her lower lumbar spine. I think that it is going to be extremely important to distinguish primary back pathology from sacroiliac pathology. I think at this point, an epidural cortisone injection could be very helpful in making that distinction as well as a sacroiliac joint injection.

08/21/12: The claimant was reevaluated. She stated that she was in a lot of pain for three days and could not stand. She said her back was still hurting and it was still uncomfortable for her to sit and stand. She rated her pain at 10. She stated PT was not helping at all. Her physical exam revealed no changes. **PLAN:** The patient completed a DDE on 08/06/12 with the reported opinion that she has not reached MMI. At this point, she is advised to revisit with the pain management specialist for further evaluation and treatment.

09/10/12: X-Ray Lumbar Spine report. **IMPRESSION:** Degenerative disc disease and facet disease as described above, please see above discussion. Mild anterolisthesis of L4 on L5, which appears to worsen in flexion and slight improve in extension. Radiopaque density over the pelvis with the appearance of bladder stone. CT scan could be performed for further evaluation.

09/10/12: The claimant was. She complained of axial low back pain rated 10/10. She was having bilateral low back discomfort with numbness and burning sensation to back of legs, stopping behind knees. Her current medications were noted to be ibuprofen. **ASSESSMENT:** Thor/lumbosacral neuritis/radiculitis.

Lumbar HNP/disc displacement without myelopathy. FOLLOWUP: 3 weeks.
LESI right L5, S1 ESI.

09/12/12: Letter of review determination from Insurance. EXPLORATION OF FINDINGS: The 09/10/12 note had no PE documented at all, so there is no current support for an ESI. The RME who did do an exam on 08/06/12 indicated normal neuro findings, so this does not support an ESI as per ODG criteria.

09/27/12: The claimant . She complained of low back discomfort and wished to discuss a stronger pain medication. She was currently taking ibuprofen 800 mg, which was not relieving the pain. PLAN: Medications: SOP – Compound cream. PRESCRIPTION: 1 Vicodin 5-500 mg tablet mg 1 p.o. t.i.d. p.r.n. #90. FOLLOWUP: LESI DR A. RT L4 and L5 – pending auth//back brace.

10/10/12: Letter of Medical Necessity. “has evidence of disc protrusion causing nerve root impingement on her MRI. Clinically, she has symptoms suggestive of a lumbar radiculopathy. Epidural steroid injections have also been recommended by her treating doctor. I am unsure as to why the carrier is denying treatment as it has been already deemed medically necessary by her other physicians. This delay in care has resulted in significant suffering to the patient and such a delay in proper care can also lead to development of chronic pain since the acute pain was not treated adequately in a timely manner. Based on all of these, I feel that the epidural steroid injections are indeed medically necessary and requested they be authorized.

10/17/12: Peer Review Report. The request for a right L4-L5 epidural steroid injection with fluoroscopy is not medically necessary. In this claimant, there was an MRI on 01/18/12 that showed a right L5-S1 posterior lateral HNP with possible nerve impingement. The claimant was requested to have an epidural steroid injection (ESI) but was denied in 07/2012 due to lack of physical therapy (PT). The claimant had PT in 07/2012 to 08/2012. There was another request on 09/12/12 for an ESI and was denied on the basis of the lack of a physical exam. There is no current support for an ESI. Radiculopathy has not been clearly established on exam. The request for sedation is not medically necessary with CPT code of 01992. Since the ESI was not considered medically necessary, this request is not supported.

11/06/12: Peer Review Report. Based on the clinical information provided, the request for right L4-L5 epidural steroid injection is not recommended as medically necessary. There is no current, detailed physical examination submitted for review to establish the presence of active lumbar radiculopathy as required by the Official Disability Guidelines. The submitted MRI does not document any significant neurocompressive pathology. Given that the requested injection is not medically necessary, the request for sedation is not medically necessary. Additionally, there is no documentation of extreme anxiety or needle phobia.

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

The previous adverse decisions are upheld. As noted by the above reviewers, there is an insufficient amount of data from the claimant’s treating physicians and physician assistants to establish a diagnosis of lumbosacral radiculopathy, which is essential to authorize a lumbar epidural steroid injection by Official Disability Guidelines. The only recent complete history and physical exam is on August 6, 2012, by the Designated Doctor who did not diagnose radiculopathy; instead, he stated there was no neurological deficit, nor atrophy, and all muscle groups were strong and symmetrical. His diagnosis was “lumbar strain/sprain with intermittent nerve irritation symptoms. Sacroiliac strain.” Therefore, the request for a Right L4-L5 Epidural Steroid Injection with Fluoroscopy, 54483 x 2 and 77003, Sedation 01992; **AMENDED: Right L4-L5 Epidural Steroid Injection with Fluoroscopy, 64483 x 2 and 77003, Sedation 01992** is not medically necessary and is non-certified.

ODG:

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| <p>Epidural steroid injections (ESIs), therapeutic</p> | <p><i>Transforaminal approach:</i> Some groups suggest that there may be a preference for a transforaminal approach as the technique allows for delivery of medication at the target tissue site, and an advantage for transforaminal injections in herniated nucleus pulposus over translaminar or caudal injections has been suggested in the best available studies. (Riew, 2000) (Vad, 2002) (Young, 2007) This approach may be particularly helpful in patients with large disc herniations, foraminal stenosis, and lateral disc herniations. (Colorado, 2001) (ICSI, 2004) (McLain, 2005) (Wilson-MacDonald, 2005) Two recent RCTs of caudal injections had different conclusions. This study concluded that caudal injections demonstrated 50% pain relief in 70% of the patients, but required an average of 3-4 procedures per year. (Manchikanti, 2011) This higher quality study concluded that caudal injections are not recommended for chronic lumbar radiculopathy. (Iversen, 2011)</p> <p><i>Fluoroscopic guidance:</i> Fluoroscopic guidance with use of contrast is recommended for all approaches as needle misplacement may be a cause of treatment failure. (Manchikanti, 1999) (Colorado, 2001) (ICSI, 2004) (Molloy, 2005) (Young, 2007)</p> <p>Criteria for the use of Epidural steroid injections:</p> <p><i>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.</i></p> <p>(1) Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.</p> <p>(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).</p> <p>(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.</p> <p>(4) <i>Diagnostic Phase:</i> 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.</p> |
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| | <p>(5) No more than two nerve root levels should be injected using transforaminal blocks.</p> <p>(6) No more than one interlaminar level should be injected at one session.</p> <p>(7) <i>Therapeutic phase:</i> 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)</p> <p>(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.</p> <p>(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.</p> <p>(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.</p> <p>(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.)</p> |
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| <p>Fluoroscopy (for ESI's)</p> | <p>Recommended. Fluoroscopy is considered important in guiding the needle into the epidural space, as controlled studies have found that medication is misplaced in 13% to 34% of epidural steroid injections that are done without fluoroscopy. See Epidural steroid injections (ESI's).</p> |
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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)**