



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 11/30/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of a transforaminal epidural steroid injection at the bilateral L3-L4 with intravenous sedation under epidurography.

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

The reviewer is a Medical Doctor who is board certified in Anesthesiology.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a transforaminal epidural steroid injection at the bilateral L3-L4 with intravenous sedation under epidurography.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed:

- IRO Request – 11/13/12
- Office Notes – 8/20/07, 4/7/08
- LHL009 – 11/13/12
- Office Notes – 7/19/04, 1/24/06, 8/3/06, 9/16/06, 4/10/07, 4/23/07, 11/24/08, 4/30/09, 12/3/09, 5/3/10, 3/11/11, 8/22/11, 12/12/11, 7/16/12, 8/23/12, 10/22/12, 10/29/12, 11/12/12
- Procedure Note – 11/9/99

Procedure Reports – 6/2/99, 6/16/99, 6/28/01, 3/10/03, 1/22/04, 5/5/04,
4/14/05, 12/8/05, 1/17/06, 8/22/06, 6/7/07

CT Lumbar w/o Cont Report – 10/17/02

Parameter Review – 6/21/07

Radiology Report – 7/31/00

Records reviewed:

MRI Report – 10/4/12

Denial Letters – 10/25/12, 11/7/12

Denial Letters – 10/25/12, 11/7/12

ODG Guidelines: Low Back Chapter – Lumbar & Thoracic

A copy of the ODG was provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Claimant is a male employee who sustained injury while he was picking up a when he heard his back 'pop'. Per OMNI notes, patient had lumbar laminectomy at L3-4 and L4-5 and interbody fusion at L4-5. He has reached MMI on 08/21/1998 with 26% improvement rating. Previous treatments include multiple epidural steroid injections. CT lumbar spine dated 10/17/2002 revealed small protrusion at L2-3 and L3-4 levels. There is postoperative change seen at L4-5. The patient has fluoroscopic implantation of trial dorsal column stimulator on 06/02/1999 and had single permanent dorsal column stimulator on 06/16/1999. On 01/17/2006, he underwent removal of implantation dorsal column stimulation lead and internal programmable generator. Lumbar MRI on 10/04/2012 revealed post-operative status. There is broad based posterior herniation of L3-4 disc, with bilateral foraminal components causing mild to moderate narrowing of the central canal and neural foramina bilaterally. The herniation measures approximately 8cm in size. There is a small broad based posterior and right paracentral as well as foraminal herniation of L2-3 disc, causing mild narrowing of the central and neural foramina bilaterally, right more than left. The herniation measure approximately 4cm in size. Small broad based herniation of L5-S1 disc, with bilateral foraminal components causing mild narrowing of the central canal and neural foramina bilaterally. The herniation measures 4cm in size. There is diffuse bulge of L1-2 disc causing mild narrowing of the central canal and neural foramina bilaterally. The bulge measure approximately 2mm in size. There is generalized facet arthropathy and mild vertebral offsets at multiple levels. Recent medical reports reveal his pain remains at a level of 8/10. Physical examination shows paraspinous tenderness, restricted lumbar range of motion and positive straight leg raising bilaterally.

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

ODG Chapter: Low Back- Lumbar and Thoracic

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 the initial use of an ESI (formally referred to 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.
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 on 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 percent 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 used 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.)

The claimant was injured in 1996 and has undergone a variety of interventions including spinal cord stimulator, epidural steroid injections and pharmacotherapy. The patient's latest physical examination shows intact sensation and motor strength that does not clinically corroborate the presence of active radiculopathy. The reports do not indicate implementation of physical therapy or home exercises. Also, the patient seems to be getting relief from the medications he is taking. There is no indication whether there will be adjunct physical rehabilitation in addition to the proposed injection. The latest physical examination, performed on 11/12/12 does not reveal any significant change in the patient's condition. His pain remains at a level of 8/10. Physical examination shows paraspinal tenderness, restricted lumbar range of motion and positive straight leg raise bilaterally. The report describes good response to medications, but there is no included VAS. There are no indications of any physical therapy regimens since 2007. Therefore, the medical necessity of this request has still not been substantiated and the requested service is not medically necessary at this time.

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)**