AccuReview

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: February 13, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left L5-S1 Transforaminal ESI w/ Fluoro 64483, 99144, 77003

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

This physician is a Board Certified Orthopedic Surgeon 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)

☐ 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:

07-28-11: MRI Lumbar Spine without IV contrast interpreted by MD

08-31-11: Progress Note by MD
12-13-11: Evaluation by MD with Pain and Spine Center
12-30-11: UR performed by MD
01-11-12: Letter of Appeal by MD
01-23-12: UR performed by MD

PATIENT CLINICAL HISTORY [SUMMARY]:

This male was injured on xx/xx/xx while operating a compactor roller. At that time he suffered a fall while unrolling phelp and since that time suffered from progressive pain in his lower back and lower extremities. He has undergone conservative treatment.

07-28-11: MRI Lumbar Spine without IV contrast interpreted by, MD. Impression: 1. L5-S1 disc herniation (There is no significant neural foraminal narrowing. Left paracentral 0.1 cm disc herniation approaches the thecal sac). 2. Possible muscle spasm. Clinical correlation is suggested.

08-31-11: Progress Note by MD. The claimant had complaints of back pain that was stabbing, numb, sharp, burning, and tingling in nature. On physical exam there was severe tenderness to deep palpation in the lumbar spine and paraspinal musculature, no paraspinal spasm. Range of motion was limited in flexion and extension due to pain. Straight leg raising was positive bilaterally at 30 degrees. There was decreased sensation to light touch in bilateral lower extremities in L4-S1 distribution. Diagnosis: 1. Thoracic or lumbosacral neuritis or radiculopathy. 2. Lumbago. 3. Displacement of lumbar intervertebral disc without myelopathy. 4. Unspecified myalgia and myositis. Plan: The claimant was prescribed Gabapentin, Xanax, and Tramadol. A diagnostic bilateral L5-S1 transforaminal epidural steroid injection was recommended.

12-13-11: Evaluation byMD with Pain and Spine Center. On physical examination flexion and extension were positive for pain in the lumbar spine. Straight leg raise was positive at L5 to the left with diminished sensation and strength. Slumps was positive for the same. Deep tendon reflexes were 3+/4. Strength was 4+/5. Diagnosis: Lower back pain syndrome, lumbar radiculopathy, lumbar muscle spasm, chronic intractable pain syndrome. Plan: The claimant was prescribed a home TENS unit for management of his myofascial pain. Dr. also recommended active rehabilitation along with injection therapy. Dr. recommended left L5-S1 transforaminal under fluoroscopic guidance and monitored anesthesia care due to the claimant having radicular-type pain unresponsive to conventional noninvasive treatments such as physical therapy, rehabilitation and the use of medication for more than four weeks.

12-30-11: UR performed by, MD. Reason for Denial: There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient's lumbar MRI does not support a diagnosis of

lumbar radiculopathy. Given the current clinical data, the requested epidural steroid injection is non-certified.

01-23-12: UR performed by MD. Reason for Denial: There is no clear objectified evidence of nerve root impingement by MRI imaging. By physical examination there is an unspecified decrease of reflex of 3+/4 but not specified to the knee or ankle on the left or right. Furthermore; there is no clear dermatomal pattern or neurologic pattern of specified clinical radiculopathy. And there is no documentation of through failure of lower levels of conservative treatment including oral medication or active home exercises or formal physical therapy. Peer reviewed guidelines indicate that radiculopathy must be objectified by physical exam findings and need to be present with corroboration of MRI imaging and unresponsiveness to conservative treatment including exercise, physical therapy, non-steroidal anti-inflammatory medications, muscle relaxants or even pain medication. It is unclear whether the claimant has undergone a prior epidural steroid injection as there has been previous request, however; without clear radiculopathy or failed lower levels of conservative care the request is no medically supported and not corroborated by imaging studies.

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

The request for Left L5-S1 Transforaminal ESI w/ Fluoro 64483, 99144, 77003 is denied. The medical records have to be clearer in physical findings to confirm a radiculopathy. We need the type of straight leg raise, the angle where pain occurred and whether it was performed prone or sitting and a comparison to the unaffected side. Reflex findings need to be clearer by indicating which reflexes were involved (i.e. Achilles, etc.) and compared to the unaffected side. Weakness needs to be compared to the unaffected side and specified to which muscle group and/or which nerve is involved. Also circumference measurements need to be documented to determine atrophy. Based on the lack of objective findings of radiculopathy on examination and lack of corroboration by imaging studies and/or electrodiagnostic testing, the request for left L5-S1 ESI does not meet ODG criteria.

ODG:

Epidural steroid injections (ESIs), therapeutic	Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition. **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)**