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Notice of Independent Review Decision

DATE OF REVIEW: 12/29/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Appeal Left L4,L5 Transforiminal Epidural Steroid Injection with fluoroscopy
Monitored Anesthesia by CRNA on call from Capital Medical Management Group Appl

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

Board Certified Physical Medicine, Rehabilitation and Pain Medicine

REVIEW OUTCOME

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

Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Clinical notes dated 09/02/2011 by Dr.
2. Past medical history form filled out by the patient by Dr. dated for 10/14/2011
3. Clinical note by Dr. dated for 10/14/2011
4. Clinical note by Dr. dated for 11/03/2011
5. An appeal letter dated for 11/10/2011
6. MRI of the lumbar spine by Dr. dated for 09/21/2011
7. Previous reviews dated for 11/17/2011 and 11/09/2011

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a who reported an injury on xx/xx/xx. According to clinical note dated xx/xx/xx, the patient was seen with chief complaints of left leg and lumbar spine pain that radiates from his low back to his left knee after a work related injury on xx/xx/xx. The patient stated that he was a lifting a strut for installation when he felt pain in his low back. The patient rates his pain an 8/10.

The patient underwent a MRI of the lumbar spine on 09/21/2011, which revealed L4-5 degenerative changes with left posterior lateral broad-based disc protrusion resulting in left lateral recess narrowing with abutment of the traversing left L5 nerve root and left neural foraminal narrowing with abutment of the left L4 nerve root.

Clinical note dated 10/14/2011 reports that the patient continues with chief complaints of low back pain and pain shooting into his left leg. Physical examination of the spine revealed no pain with palpation to paraspinal musculature. There was no costovertebral angle tenderness to percussion on either side. Abdominal examination showed no masses or palpable structures. The patient was reported to have limited range of motion of the thoracic lumbar spine with flexion down to his mid tibias, extension to 15 degrees, and lateral flexion to 25 degrees and rotation to 35 degrees to the left and to the right. The patient had pain with palpation of the left sciatic notch, but none noted on the right. Lower extremity examination revealed that the patient was intact to sensation to light touch in the L1-S1 dermatomes bilaterally. Manual motor testing showed there to be 5/5 strength of the gastrocnemius soleus, peroneal, extensor hallucis longus, tibialis anterior, quadriceps and iliopsoas motor groups. Deep tendon reflexes were 2+ and symmetric at the patellar tendons and Achilles bilaterally. The patient had a positive straight leg raise sign to the left and negative to the right.

Clinical note dated 11/03/2011 reports that the patient has had treatments and improved his symptoms with the use of traction, muscle stimulator unit use, chiropractic manual medicine care, medication and physical therapy exercise regimen. The patient continues with muscle pain and numbness and tingling.

Prior review dated for 11/09/2011 reports that the patient was denied due to lack of evidence that the patient has been treated conservatively, such as exercise, physical methods, NSAIDS and muscle relaxants. Prior review dated 11/17/2011 reports that the patient was denied an epidural steroid injection due to the failure of conservative treatments such as physical therapy, pharmacotherapy and no indication that the requested service was part of an evidence-based rehabilitative plan aimed at restoration of function.

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

The patient reported an injury on xx/xx/xx and had complaints of left leg and lumbar spine pain. The patient underwent a MRI which revealed L4-5 degenerative change with left posterolateral broad-based disc protrusion resulting in left lateral recess narrowing

with abutment of the traversing L5 nerve root and left neural foraminal narrowing with abutment of the L4 left nerve root. Upon physical examination, there was pain on lumbar spine range of motion with a note of antalgic gait with reduced sensation at the L4 distribution, reduced left patellar and Achilles reflexes at 0+/5 and intact motor strength. The patient had a positive straight leg raise. Evidence-based guidelines state that epidural steroid injections are recommended if the patient has radiculopathy that has been documented upon physical examination and corroborated with imaging studies and/or electrodiagnostic testing. Evidence-based guidelines also state that the patient must have failure of trial of conservative treatment prior to an epidural steroid injection. The request for a left L4-5 transforaminal epidural steroid injection with fluoroscopy monitored with anesthesia by a CRNA is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

REFERENCES: Official Disability Guidelines, Low Back Chapter, Online Version. Sacroiliac joint radiofrequency neurotomy

Not recommended. Multiple techniques are currently described: (1) a bipolar system using radiofrequency probes (Ferrante, 2001); (2) sensory stimulation-guided sacral lateral branch radiofrequency neurotomy (Yin, W 2003); (3) lateral branch blocks (nerve blocks of the L4-5 primary dorsal rami and S1-S3 lateral branches) (Cohen, 2005); & (4) pulsed radiofrequency denervation (PRFD) of the medial branch of L4, the posterior rami of L5 and lateral branches of S1 and S2. (Vallejo, 2006) This latter study applied the technique to patients with confirmatory block diagnosis of SI joint pain that did not have long-term relief from these diagnostic injections (22 patients). There was no explanation of why pulsed radiofrequency denervation was successful when other conservative treatment was not. A > 50% reduction in VAS score was found for 16 of these patients with a mean duration of relief of 20 ± 5.7 weeks. The use of all of these techniques has been questioned, in part, due to the fact that the innervation of the SI joint remains unclear. There is also controversy over the correct technique for radiofrequency denervation. A recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. (Hansen, 2007) See also Intra-articular steroid hip injection; & Sacroiliac joint blocks.

Recent research: A small RCT concluded that there was preliminary evidence that S1-S3 lateral branch radiofrequency denervation may provide intermediate term pain relief and functional benefit in selected patients with suspected sacroiliac joint pain. One, 3, and 6 months after the procedure, 11 (79%), 9

(64%), and 8 (57%) radiofrequency-treated patients experienced pain relief of 50% or greater and significant functional improvement. In contrast, only 2 patients (14%) in the placebo group experienced significant improvement at their 1-month follow-up, and none experienced benefit 3 months after the procedure. However, one year after treatment, only 2 patients (14%) in the treatment group continued to demonstrate persistent pain relief. Larger studies are needed to

confirm these results and to determine the optimal candidates and treatment parameters for this poorly understood disorder. (Cohen, 2008)

Facet joint diagnostic blocks (injections)

Criteria for the use of diagnostic blocks for facet “mediated” pain:

Clinical presentation should be consistent with facet joint pain, signs & symptoms.

1. One set of diagnostic medial branch blocks is required with a response of $\geq 70\%$. The pain response should last at least 2 hours for Lidocaine.
2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.
3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).
5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.
6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.
7. Opioids should not be given as a “sedative” during the procedure.
8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.
9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.
10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)
11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)]