

# CASEREVIEW

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## Notice of Independent Review Decision

**DATE OF REVIEW:** June 7, 2012

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

ODG Transforaminal ESI Bil L4-5 64483

### **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 or not medical necessity exists for each of the health care services in dispute.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

03/15/96: Operative Report by MD  
07/18/97: Operative Report by MD

01/10/00: Operative Report by MD  
10/05/00: Functional Capacity Evaluation by MD  
08/26/06: MRI Lumbar Spine with Contrast interpreted by MD  
06/20/11: Office Visit by MD  
10/11/11: Office Visit by MD  
01/31/12: Office Visit by MD  
04/24/12: Office Visit by MD  
05/04/12: UR performed by MD  
05/23/12: UR performed by MD

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who was injured on xx/xx/xx. The claimant's low back pain became severe while shoveling asphalt. It was reported that his condition had been coming on for some time. The claimant was treated with injections which helped for a short time. An MRI was ordered and disc surgery followed.

On March 15, 1996, Operative Report by MD. Postoperative Diagnosis: Herniated lumbar disc and foraminal stenosis at L4-L5. Procedure: Lumbar laminotomy and foraminotomies at L4-5 bilateral with excision of disc at L4-5.

On July 18, 1997, Operative Report by MD. Postoperative Diagnosis: Lumbar stenosis, L4-5 and L5-S1, with disc herniation, L4-5 and L5-S1. Procedures: 1. Lumbar foraminotomy, bilateral, L4-5 and L5-S1. 2. Excision of discs, L4-5 and L5-S1, right side. 3. Hemilaminectomy, L5.

On January 10, 2000, Operative Report by MD. Postoperative Diagnosis: Multiple level foraminal stenosis bilateral L4-5 and L5-S1 with some disc prolapsed. Procedures: 1. Bilateral foraminotomy L4-5, L5-S1. 2. Excision of some disc material at L5-S1 on the right side.

On October 5, 2000, the claimant underwent a Functional Capacity Evaluation by MD who opined that the claimant could work and would be able to perform a sedentary occupation based on the results of the FCE.

On August 28, 2006, MRI of the Lumbar Spine with Contrast, Impression: 1. Post laminectomy changes at L4 and L5. 2. The thecal sac is displaced posterior in the spinal canal at L4/L5 and L5/S1 with soft tissue density in front of the thecal sac showing enhancement and is consistent with scar material. 3. Narrowing of the neuroforamina at L4/L5 and L5/S1 approaches 75% or greater. 4. Mild spinal stenosis at L3/L4 with neuroforaminal narrowing of 50 to 75%.

On June 20, 2011, the claimant was seen by, MD for medication compliance. The claimant had complaints of low back pain that radiated down bilateral extremities to the toes, left greater than the right. He stated he had burning sensations at times in both legs and numbness in both feet. Pain Profile: Current pain: 4; Best per last 30 days: 2; Worst per last 30 days: 7. The claimant stated his medications

were approximately 75% effective. Current medications were listed as: Norco 10/325, Klonopin 1 mg, Celebrex 200 mg, Soma 350 mg and Lyrica 75 mg. Dr. noted that the claimant had physical therapy and epidural steroid injections without significant relief. Diagnosis: Chronic pain syndrome, Postlaminectomy syndrome of lumbar region, Lumbar radiculopathy, and impotence of organic origin.

On October 11, 2011, the claimant was seen by MD for medication compliance. Pain Profile: Current pain: 3; Best per last 30 days: 1; Worst per last 30 days: 7.

On January 31, 2012, the claimant was seen by MD for medication compliance. Pain Profile: Current pain: 3; Best per last 30 days: 2; Worst per last 30 days: 6.

On April 24, 2012, the claimant was seen by, MD for complaints of low back pain that radiated down bilateral to the feet, left much greater than the right. The claimant denied any significant problems with the medications. He stated with the medications he was able to perform normal daily activities. The claimant was requesting to have some kind of injections done to help with his left leg pain. It was reported that the claimant had epidural injections performed between his 3<sup>rd</sup> and 4<sup>th</sup> spine surgeries and he received physical therapy in Longview in 1998. It was reported he had little benefit from the procedures and treatments. Pain Profile: Current pain: 2; Best per last 30 days: 1; Worst per last 30 days: 7. Current medications: Norco 10/325 60% effective, Klonopin 1 mg 80% effective, Celebrex 200 mg 80% effective, Flexeril 10 mg 50% effective, and Lyrica 75 mg 50% effective. On physical examination the claimant had tenderness in lumbar spine increased with movement, extension and flexion. Positive allodynia in left calf. Knee, Achilles and Hamstrings DTRs were +2 bilaterally. There was decreased sensation to pinprick in bilateral ankles. Motor strength was 5/5 in bilateral upper and lower extremities. Diagnosis: Chronic pain syndrome, Postlaminectomy syndrome of lumbar region, Lumbar radiculopathy, and Impotence of organic origin. Recommendations: 1. Continue current medications. 2. Refer to Dr. for psych evaluation. 3. Obtain records of physical therapy. 4. Refer to physical therapy. 5. Pre-cert for TF-ESI bilateral L4-5 with IV sedation.

On May 4, 2012, MD performed a UR on the claimant. Rationale for Denial: As per 4/24/12 report, there is tenderness in lumbar spine associated with movement. There is positive allodynia in the left calf. There is decreased sensation to pinprick in bilateral ankles. However, there was no comprehensive pain assessment with oral pharmacotherapy, utilizing VAS scores as needed, and which should include: the least reported pain over the period since last assessment; average pain; intensity of pain after taking the medications; how long it takes for pain relief; and how long pain relief lasts. The findings on recent MRI of the spine are not available. L4-5 radiculopathy is not substantiated clinically. Moreover, there was no objective documentation of exhaustion or failure of conservative treatments such as medications, activity modification and physical therapy. Progress reports of the previous PT visits to validate functional response

from the rendered sessions were not provided. Furthermore, there was no indication that the procedure will be in conjunction with other rehabilitative efforts. Documented analysis of any recent imaging studies and electrodiagnostics done were also not submitted. On these grounds, this request is not substantiated at this time.

On May 23 2012, MD performed a UR on the claimant. Rationale for Denial: There was still no objective documentation of failure of response to recommended conservative treatments such as oral pharmacotherapy or rehabilitation through VAS pain scales and physical therapy progress reports. The patient's latest lumbar MRI and EMG of the bilateral lower extremities was dated on 2006 and there was still no report of any updated imaging or electrodiagnostic studies to support the diagnosis of radiculopathy. There was still no objective documentation that the patient would pursue other forms of conservative treatment such as physical therapy or compliance with a home exercise program in conjunction with the request. Furthermore, the patient's injury was noted on 1995 and he has undergone four lumbar surgeries. Reference guidelines state that there are decrease success rates for ESI following chronic duration of symptoms and previous back surgery. For the above reasons, the medical necessity for this request cannot be established at this time.

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

Denial of ESI Bilateral L4-5 is upheld/agreed upon. Per ODG Low Back Chapter, recent exam does not objectively document radiculopathy and submitted MRI is nearly 6 years old and there is no electrodiagnostic study submitted to corroborate suspected nerve root irritation at bilateral L4-5 level. Therefore, the request for Transforaminal ESI Bil L4-5 64483 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)**