

# Medical Assessments, Inc.

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## Notice of Independent Review Decision

August 20, 2013

### **IRO CASE #:**

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

L5-SI Epidural Steroid Injection

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

The Reviewer is Board Certified in the area of Orthopedic Surgery with over 44 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:**

06/18/2012: Initial Report  
07/03/2012: Functional Capacity Evaluation report  
08/22/2012: Functional Capacity Evaluation Report  
02/11/2013: Progress Summary  
02/19/2013: UR performed regarding Chronic Pain Management program  
02/21/2013: Request for Reconsideration  
04/19/2013: Progress Summary and Treatment  
05/06/2013: Evaluation performed  
05/23/2013: UR performed  
06/04/2013: Evaluation  
06/18/2013: Evaluation  
06/20/2013: UR performed  
07/24/2013: Evaluation performed

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

The claimant is a male who was initially involved in a motor vehicle accident on xx/xx/xx. The claimant suffered multiple injuries and was transported to the hospital where he was admitted with a ruptured spleen. The claimant had a splenectomy and abdominal support surgery and began therapy program.

06/18/2012: Initial Report. Claimant reported that he was having constant sharp and burning pain in the area of the low back with the pain radiating down the right leg. He stated prolonged sitting, walking and standing increase the severity of his low back pain. Claimant states he was feeling constant, sharp and dull pain in the area of the cervical spine. The claimant was asked to rate his overall pain on a 1-10-pain scale. He rated his pain at a 9. Claimant stated his normal daily activities have become difficult to perform since his accident. On physical examination of the spine by palpation revealed a medium degree of apin at C1-C7 and L1-L5 bilaterally. Palpation of the muscles revealed a moderate amount of muscle tightness of the lumbar paraspinal muscle bilaterally. Motor examination demonstrated weakness in the right hip flexors graded 4/5. Deep tendon reflexes in the lower extremities were diminished. Assessment: The prognosis is considered guarded at this time.

Treatment Plan: Due to the recent injury, the claimant is suffering from significant amount of pain. Recommend conservative chiropractic treatment that will consist of manual manipulations and passive modalities.

05/06/2013: Evaluation performed: It was reported that once the claimant began therapy program, he did not notice the multiple areas of pain. The main pain that makes up 50% of the symptoms is a sharp throbbing lumbar pain that began after the abdominal staples were removed. The overall pain is intermittent and variable and at times quite severe. The baseline pain changes from zero to 9 on a scale of 10. Aggravating conditions include squatting, flexion, coughing, sneezing or having a bowel movement. Alleviating conditions include medications, ice. Claimant denies having had any bowel and or bladder accidents. Claimant indicated that the right leg numbness that began on October of 2012. The symptoms began after he was examined for a second medical opinion and was asked to move the spine in different directions. The numbness radiated along the lateral aspect of the thigh, lateral knee, lateral lower leg and lateral of the foot. The symptoms are constant but variable and worsened when the lumbar pain increases. Alleviating conditions occur only when the lumbar pain improves. The claimant reported that physical therapy and chiropractic treatment worsened his overall symptoms. Claimant reports having one facet block injection that provided complete relief of his lumbar pain for two days. At that point the symptoms had worsened and he found it more difficult to participate in his activities of daily living.

05/23/2013: UR performed. Rationale for Denial: The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. Based on Official Disability Guidelines, the role of the proposed injection cannot be supported. The claimant's physical examination demonstrates sensory

deficit to the right lower extremity in an L1 through S1 fashion with no concordant exam findings specific to the L5-S1 level to support the role of the proposed injection. Furthermore, on MR imaging, the claimant's L5-S1 level is with a disc protrusion resulting in only mild bilateral neuroforaminal narrowing. The lack of clinical correlation between compressive etiology on imaging and formal examination supportive of the deficit at the L5-S1 level would fail to necessitate the role of the proposed epidural injection at the present.

06/04/2013: Evaluation. Physical Exam: The claimant stands up from a seated position in a slow guarded motion. The Lumbar spine has a very guarded motion that exacerbates on extension, lateral tilt, and flexion. There is tenderness of the lumbosacral region. The lower extremities are motor intact with a decreased sensation throughout the right lower extremity. He is able to flex down to the mid lower legs. Assessment: 1. Lumbar herniated disk. 2. Cervical herniated disk. 3. Cervicalgia. 4. Cervical radiculopathy. 5. Lumbago. 6. Lumbar radiculopathy. Plan: They received denial from the previously requested EMG as well as the requested ESI. They would submit reconsideration for both.

06/18/2013: Evaluation performed. On physical examination the claimant's range of motion of the lumbar spine was guarded secondary to pain. The right lower extremity had decreased sensation throughout the entire extremity. Reflexes were symmetrical. Straight leg test on the right was positive at 60 degrees. Assessment: Lumbar herniated disk, Cervical herniated disk. Discussion/Plan: An EMG/NCS is indicated to better evaluate the patient's lumbar radiculopathy. The patient had a lumbar facet block in the past. requested a right L5-S1 epidural injection to relieve claimant's back and right leg pain. It is a medical necessity to do a thoracic MRI to better evaluate his right leg numbness.

06/20/2013: UR performed. Rationale for Denial: The request was non-certified on May 23, 2013, due to lack of clinical correlation between physical examination findings and deficits on diagnostic imaging supporting evidence of nerve root impingement or radiculopathy. Additional documentation provided for review includes a progress note from June 4, 2013; however, they physical examination findings noted do not correlate with diagnostic imaging as the lower extremity decreased sensation does not pertain to a specific dermatomal distribution indicating pathology at the L5-S1 level. Furthermore, diagnostic imaging consisting of the MRI notes evidence of disc protrusion at L5-S1 with mild bilateral neuroforaminal narrowing without significant nerve root impingement indicating a need to proceed with epidural steroid injection at this time. Full documentation of conservative treatment failure, such as formal physical therapy has not been provided in the records reviewed. The guidelines would not support proceeding with injection without full exhaustion of conservative treatment modalities.

07/24/2013: Evaluation performed. Claimant reported that his stabbing lumbar pain still constant and variable and can reach levels of 8 on a scale of 0-10. Tramadol decreased symptoms, at no point actually comfortable. The lower extremity radicular pain that radiates through the right posterior leg could be also just as aggressive to the levels of 6 on a scale of 0-10. Extended periods of

activity are the primary triggering mechanism. Physical exam: The lumbar spine has a very guarded limited range of motion that exacerbates on the flexion, extension, and rotation. There is tenderness of the paraspinal muscle, right greater than the left. The lower extremities have a decreased sensation throughout the entire right leg. There is a positive right straight leg raise test and diminished right Achilles reflex. There is muscular atrophy of the right thigh measuring 3.5 cm in diameter while the left is 40. The right calf measures 33 cm in diameter and the left measures 34. Plan: indicates that the lumbar MRI revealed disk pathology at the L5-S1 level with disk herniation that causes neuroforaminal narrowing and an indentation of the thecal sac. He also states the EMG correlates with these findings as well as the neurological changes that are taking place. Re-submit for approval.

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

The previous adverse determinations are upheld. The supplied medical records and documented physical examinations indicate a sensory deficit to the entire right lower extremity. According to the prior UR reports, MRI imaging revealed evidence of disc protrusion at L5-S1 with mild bilateral neuroforaminal narrowing without significant nerve root impingement. An actual MRI report was not provided for review nor were the EMG report references. There is a lack of clinical correlation between MRI imaging and clinical findings on physical examinations. Therefore, the request for L5-S1 Epidural Steroid Injection does not meet ODG criteria and is denied.

### **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)**