

# CASEREVIEW

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Notice of Independent Review Decision

**[Date notice sent to all parties]:** December 10, 2013

**IRO CASE #:**

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

Repeat Bilateral L4-5, L5-S1 Lumbar ESI 64483, 64484, 99144, 72275

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

This physician is Board Certified in Physical Medicine and Rehabilitation with over 18 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:**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male was injured on xx/xx/xx. An MRI revealed a large left lateral protrusion impinging upon the left L4 nerve root for which he underwent a left L4-5 laminectomy on December 2, 1999. He underwent a repeat decompression attempt at L4-5 bilaterally on July 6, 2002. His pain has been managed with medications and injections.

On June 22, 2004, MRI Lumbar Spine, Impression: 1. Multilevel Spondylosis change, but no focal disc protrusion. 2. Mild spinal stenosis at L3-4 and borderline spinal stenosis at L2-3. 3. Moderate right L4-5 foraminal stenosis with some impingement of the right L4 nerve root. 4. Prior surgery of L4-5 level.

On August 16, 2004, Operative Report by MD. Postoperative Diagnosis: 1. Failed back syndrome with radiculitis in bilateral lower extremities. Procedures performed: 1. Racz catheter with caudal epidural steroid injection. 2. Mechanical and chemical lysis of adhesions. 3. Epidurogram. 4. IV sedation. 5. Fluoroscopy.

On March 28, 2006, MRI Lumbar Spine, Impression: 1. Multilevel degenerative disc disease and degenerative facet disease as described above with multilevel lumbar spondylosis. There is no moderate or severe spinal stenosis at any level. Moderate stenosis of the interior aspect of the right L4 foramen is present related to disc space narrowing and posterolateral degenerative spondylosis. The exiting root sleeve is slightly crowded within the right neural foramen. 2. Postoperative changes at L4-L5.

On April 2, 2006, Operative Report by MD. Operations Performed: 1. Transforaminal epidural steroid injection, left L4. 2. Transforaminal epidural steroid injection, left L5. 3. IV sedation. 4. Fluoroscopy. 5. Epidurogram via the transforaminal approach.

On April 23, 2008, MRI Lumbar Spine, Impression: 1. Multilevel degenerative disc disease and degenerative facet disease as described above with multilevel changes of lumbar spondylosis. These changes accentuate a developmentally small central spinal canal at L2-3 and L3-4. 2. Postoperative changes at L4-5. 3. L4 foraminal stenosis on both sides related to disc space narrowing and posterolateral degenerative spondylosis. This is greatest on the right where there is some crowding of the exiting root sleeve within the right neural foramen.

On May 12, 2011, MRI Lumbar Spine, Impression: 1. Status post L4-L5 laminectomy. Spinal canal is patent; however, the neural foramina are severely narrowed at this level. 2. Multilevel spondylosis change throughout the remainder of lumbar spine with moderate disc height loss and disc bulging throughout. Spinal canal and neural foramina, otherwise, remain largely patent. 3. Severe left-sided facet arthropathy at L5-S1. No listhesis.

On March 6, 2013, the claimant was evaluated by PA for continued low back pain with radiation to both legs. Pain rated 10/10. Reports of more severe pain since weaning off of Oxycontin and is managing with Norco alone, but pain is excruciating. Waiting on referral for spinal cord stimulator. Diagnosis: 1. Postlaminectomy Synd Lumbar, 2. Chronic Pain Syndrome, 3. Lumbosacral Neuritis Radiculopathy, 4. Encounter Long RX Use OT. Plan: Refill Norco.

On June 10, 2013, the claimant was evaluated by PA for pain radiating to the bottoms of his feet with a sharp, burning sensation, which is a change in the usual character of his pain. Reports of a successful spinal cord stimulator trial and needs an implantation. Active Medication List: Cymbalta, Flexeril, OxyCodone, Oxycontin. Physical Exam: Nonantalgic gait, walks on toes and heels with difficulty. There is tenderness upon palpation of the lumbar midline. ROM limited due to pain. Motor Strength: 4/5 knee flexion, knee extension, toe dorsiflexion, foot plantar flexion on the left. Sensation to touch and pinprick was decreased on the lateral part of the foot, dorsum of the foot on the right and absent in all dermatomes on the left. Right patella reflex 1+, right ankle reflex 0, left patella and ankle reflexes were 0. Straight Leg Raise Test was positive bilaterally. Plan: Continue with present medication regimen and add Gabapentin. Refer to Dr. for a spinal second opinion.

On September 9, 2013, the claimant was evaluated by MD for continued low back pain with radiation into the right leg. It was reported he started having numbness in the right leg. He was still awaiting permanent Spinal Cord Stimulator system implantation. Physical examination: Antalgic gait favoring right leg, unable to walk on heels and toes. With palpation there was muscle spasm in both paravertebral muscle groups. There was tenderness and palpable trigger points in the para-vertebral areas. There was pain on pressure over the lumbar facet joints bilaterally. He did not report pain with applying pressure over sacro-iliac joints. There was limited ROM due to pain. Strength was 4/5 in right toe dorsiflexion, foot eversion and foot plantar flexion. Sensation to touch and pinprick was decreased on the right lateral part of the foot and dorsum of the foot. Left patella reflex was 1+, left ankle reflex was 0, Right patella reflex was 1+, and right ankle was 0. Kemp's test was positive over the lower lumbar facet joints. Laseque's test was positive for lower back pain at 60 degree elevation with pain radiation to the posterior thigh and ankle down to the foot and toes on the right side. Active Medication List: Cymbalta 30 mg, Flexeril 10 mg, OxyCodone HCL 10 mg, and OxyContin 10 mg extended release 12 hr. Because the claimant had

failed conservative therapy and pain was progressively increasing with worsening radicular symptoms, a lumbar ESI was recommended with another round of PT.

On September 26, 2013, Procedure Note by MD. Procedures: Bilateral L4-5, L5-S1 Lumbar Epidural Steroid Injection. Fluoroscopic Guidance for Needle Localization. IV Sedation for Acute Situational Anxiety.

On October 9, 2013, the claimant was evaluated by PA who reported 65-85% improvement in pain score, 60-70% improvement in ability to perform activities of daily living and 85% improvement in quality of sleep following the ESI. Radicular symptoms down the left leg resolved following the ESI. Low back pain improved as well, but continued to have radicular symptoms down his right leg. Pain was now scored a 6/10. Plan: Right L4-5, L5-S1 Lumbar ESI. Prescription: Cyclobenzaprine HCl 10 mg tablet, 1 tablet orally 3 times per day; Gabapentin 300 mg, 1 capsule orally 3 times per day for neuropathy; Norco 10-325 MG, 1 tablet orally every 6 hours as needed.

On October 15, 2013, MD performed a UR. Rationale for Denial: Official Disability Guidelines state that epidural steroid injections are recommended as a possible option for short-term treatment of radicular pain. Injections are used in conjunction with active rehab efforts. The purpose for an ESI is to reduce pain and inflammation, thereby facilitating progress in more active programs, reduction of medication use, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications and functional response. There should be pain relief of at least 50-70 percent for at least 6-8 weeks to support additional blocks. As per the latest clinical note submitted on 09/26/13, the patient received epidural steroid injections at that time. There is no documentation following that office visit that provides evidence of objective functional gains received following the initial injections. Also, the prior injection was only provided two and a half weeks ago which does not meet guideline criteria to include 50-70 percent pain relief for at least 6-8 weeks. Therefore, a repeat injection cannot be determined as medically necessary at this time.

On November 5, 2013, MD performed a UR. Rationale for Denial: The documentation submitted for review elaborates the patient complaining of low back pain with radiation of pain into the lower extremities. The patient is noted to have undergone a prior ESI on 09/26/13. The Official Disability Guidelines recommends repeat ESI's provided the patient meets specific criteria to include a 50-70 percent reduction in pain for 6-8 weeks along with an objective functional improvement. The clinical notes indicate the patient having a significant reduction in pain. No information was submitted regarding ongoing radiculopathy to include reflex, sensation or motor deficits in the appropriate distribution. The request appears to be premature as well as a 6 week interval has not elapsed.

On November 7, 2013, the claimant was evaluated by PA who reported 65-70% improvement in pain, 60% improvement in ability to perform activities of daily living, 85% improvement in quality of sleep, and 0% reduction in use of analgesic medications. He still reported complete relief of radicular symptoms in his left leg. Low back pain and right radicular leg symptoms still persisted. Pain score was 7/10. Plan: Lumbar ESI.

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

Denial of the repeat ESI is upheld/agreed upon. The time frame of 6-8 weeks since the injection is satisfied, but there are no objective improvements in pain with the average pain level going from 7-8.5/10 on 9/26/13 to 6-9/10 on 11/7/13, no objective reduction in pain medications (with reports of 0% reduction), and no objective improvement in function with no noted exam on 11/7/13. The request for Repeat Bilateral L4-5, L5-S1 Lumbar ESI 64483, 64484, 99144, 72275 is not found to meet ODG criteria and therefore is not 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)**