

Health Decisions, Inc.

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Notice of Independent Review Decision

[Date notice sent to all parties]: December 9, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OP Lumbar ESI at L4/5 62311 (PNR 77003)

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

This physician is Board Certified in Anesthesiology with over 6 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 who sustained an injury on xx/xx/xx when an overhead door hit him, causing him to fall to the ground. The claimant had complaints of right shoulder, neck, upper back and low back pain. Pain has persisted despite appropriate conservative care including medications, physical therapy and

rehabilitative efforts, and prior ESI on 10/18/10.

09-16-10: MRI of the Lumbar Spine interpreted by MD. Impression. 1. 2mm posterior disc protrusion at L5-S1. 2. Mild disc desiccation at L5-S1. 3. Mild degenerative facet joint hypertrophy from L3-L4 through L5-S1.

07-11-11: Neurophysiological Consultation and Report of Electrodiagnostics of Bilateral Upper and Lower Extremities by MD. Impression: 1. EMG/NCV evidence most consistent with a traction injury of the right brachial plexus with secondary underlying cord involvement or radiculopathy. 2. No NCV evidence of generalized peripheral neuropathy. 3. No NCV evidence of median or ulnar entrapments. 4. No EMG evidence of recurrent lumbar radiculopathy.

06-07-13: Evaluation Report by DO. Current Complaints: Slight worsening of his lower back and right leg pain has shown a slight increase in severity. Physical Examination: Hamstring Reflex on the left was 2+/5, right 2/5; Patella reflex bilaterally was 2/5; Achilles reflex bilaterally was 2/5. Milgram's test was positive. Straight Leg Raise Test was positive bilaterally. Muscle testing in the lower extremities was 4/5 in all muscles bilaterally. Diagnosis: Displacement of lumbar intervertebral disc without myelopathy. Plan: Referring out for a pain management evaluation. Flexeril and Ibuprofen were prescribed.

09-11-13: Follow Up Office Visit Report by DO. The claimant was complaining of lumbar spine consistent with a lumbar disk disruption and lumbar radiculopathy and positive right straight leg raising sign. Pain described as 6 to 8/10. Reports difficulty walking and has a problem with flexion. Reported some improvement with gabapentin. Norco refilled. Lumbar epidural blockade recommended.

09-30-13: UR performed by MD. Rationale for Denial: Guidelines recommend ESI for patients with objective evidence of radicular pain who have failed conservative care. This patient is noted to have remained symptomatic despite having utilized various conservative treatment modalities. However, motor and sensory deficits consistent with L4-5 radiculopathy were not documented in the

latest physical examination to clinically warrant an ESI at this level. Corroborative imaging and/or electrodiagnostic finding were also not noted. Based on these grounds, the medical necessity of this request is not substantiated.

10-28-13: UR performed by MD. Rationale for Denial: The updated medical report dated 10/10/13 states that the patient has back, buttock and leg pain. On physical examination of the lumbar spine, there is moderate lumbar interspinous tenderness and positive Straight Leg Raising test on the right. However, specific dermatomal and myotomal deficits attributable to L4-5 nerve root impingement are still not noted. Definite diagnosis of radiculopathy at L4-5 level cannot be ascertained. In agreement with the previous determination, the medical necessity of the request has not been established.

11-07-13: Follow Up Office Visit Report by DO. Claimant had myofascial trigger point tenderness in his lumbar spine. Rest of evaluation regarded neck and shoulder complaints.

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

The previous adverse determinations are upheld. Despite the additional information provided from the office visits and examinations on 10/10/13 and 11/07/13, there still lacks definitive documentation of radiculopathy. Physical examination of the lumbar spine shows myofascial trigger point tenderness, moderate lumbar interspinous tenderness and positive straight leg raising test on the right. However, physical examinations still lacks specific dermatomal and myotomal deficits attributable to L4-5 nerve root impingement. Therefore, this request for OP Lumbar ESI at L4/5 62311 (PNR 77003) cannot be certified at this time.

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)**