Health Decisions, Inc.

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Notice of Independent Review Decision

[Date notice sent to all parties]: October 4, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
In office epidural steroid injection, at L5-S1 with fluoroscopy for the lumbar spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The physician is a Board Certified Anesthesiologist with over 5 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:
03-01-13: Lumbar spine series, three views
04-02-13: Initial Office Visit
04-09-13: Physical Therapy Evaluation
04-18-13: Physical Therapy Daily Progress Note
04-23-13: Physical Therapy Daily Progress Note
04-30-13: Physical Therapy Daily Progress Note
05-02-13: Physical Therapy Daily Progress Note
05-02-13: Follow up Office Visit
05-07-13: Physical Therapy Daily Progress Note
05-09-13: Physical Therapy Daily Progress Note
05-14-13: Physical Therapy Daily Progress Note
05-16-13: Physical Therapy Daily Progress Note
05-21-13: Physical Therapy Re-Evaluation/Discharge
05-23-13: Physical Therapy Daily Progress Note
07-25-13: MRI of the Lumbar Spine without contrast
08-16-13: Follow-up and EMG and NCV Study

08-22-13: UR performed
09-09-13: UR performed
09-16-13: Prospective IRO Review Response

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male, who was injured on xx/xx/xx. He was driving a truck when it was hit from behind by another vehicle and threw him backwards and bounced forward. He immediately felt pain in the lower back. He was initially seen and referred to who prescribed medications and released him to work with restrictions.

March 1, 2013, Lumbar Spine Series, Three views, Impression: Stable lumbosacral spondylosis without acute compression fracture or subluxation.

April 2, 2013, the claimant was seen in the office for continued pain in lower back that radiated to the right buttock and down the right thigh. He was experiencing some numbness and tingling sensation in the right leg. He complained of muscle tightness in the lower back, and pain in both hips. On physical examination there was tenderness of the lumbosacral spinous processes and paravertebral muscles with tightness. There was tenderness of the right SI joint as well as sciatic notch. ROM was: Flexion 60 degrees, Hyperextension 25 degrees, Right Lateral Ben 25 degrees and Left Lateral Bend 25 degrees. Moto Exam/Strength was normal in the bilateral lower extremities. Sensation Exam was normal in the bilateral lower extremities. Reflexes were normal bilaterally in the lower extremities. Straight Leg Raise was negative bilaterally. Impression: Lumbar sprain and strain, and Hip pain, right. Plan: Physical therapy with modalities and emphasis on strengthening and stretching exercises. Continue medications of Flexeril and Ibuprofen.

April 9, 2013, the claimant had a physical therapy evaluation where therapy was recommended 3 days a week for 6 weeks.

May 2, 2013, the claimant had a follow up visit who noted he presented with continued pain that was worse in the morning and the evening. It was reported that in the last month the pain had been worse, and that the medications made the pain better, but walking for a long period of time and sitting to long aggravated the pain. On physical examination there was lower back tenderness and spasm. Tenderness of the lumbosacral spinous processes and paravertebral muscles with tightness. As well as tenderness of the right SI joint and sciatic notch. There was decreased ROM and positive Patrick's sign on the right leg. There was numbness and tingling of the right leg. Rybix Odt 50 mg was prescribed.

May 21, 2013, the claimant was seen for physical therapy re-evaluation. It was noted that the claimant was making progress toward the prescribed goals and that treatment should continue as planned.

July 25, 2013, MRI of the Lumbar Spine without contrast. Impression: 1. Foraminal stenosis greatest at L3-4 bilaterally and L4-5 on the left. 2. Facet arthropathy and discogenic change at levels detailed above. 3. No fracture.

August 15, 2013, the claimant was seen for a follow up office visit and underwent an EMG/NCV. It was reported that the claimant had been receiving physical therapy and takes medications but the pain persists. The pain was noted to radiate down the legs and is associated with numbness and a tingling sensation. The pain is aggravated by prolonged walking, standing, lifting, bending down, and other activities. On physical examination there was tenderness of the spinous processes and paralumbar muscles. There was some muscle tightness noted. Straight Leg Raise was positive bilaterally in the back only. There was bilateral sciatic notch tenderness. Heel walking was abnormal on the right. Patrick's Maneuver was negative bilaterally. Strength in the lower extremities was normal with some weakness of the left EHL. Normal sensation to monofilament in the lower extremities. Deep tendon reflexes in the lower extremities were normal bilaterally. Electrodiagnostic Study Report Impression: 1. There are electrophysiologic findings of bilateral L5 radiculopathy, left more than right. 2. There are no electrophysiologic findings to suggest peripheral neuropathy. Recommendations: 1. He could benefit from interlaminar epidural steroid injection at L5-S1 level under fluoroscopy to decrease pain and radicular symptoms. 2. He will continue current medications. 3. Continue current work restrictions.

August 22, 2013 performed a UR. Rationale for Denial: A lumbar ESI is not reasonable and/or necessary unless PT has been trailed. Additionally, there is no evidence of herniated disc, nerve root compression or lumbar stenosis on the 7/25/13 MRI at L5-S1 level and the physical examination shows no evidence of radiculopathy (no neurological deficits). Electromyogram (EMG also called electrodiagnostic studies) result is not sufficient to justify an ESI as there is no correlation to MRI findings or examination.

September 9, 2013 performed a UR. Rationale for Denial: The MRI of July 25, 2013 and the physical exam showed no evidence of radiculopathy. The electrodiagnostic study results were not sufficient to justify epidural steroid injections as there was no correlation to MRI findings. No additional medical documentation was provided for review for the appeal process. The previous denial is supported as the electrodiagnostic studies reported bilateral L5 radiculopathy, left more than right. There was no documentation of nerve root impingement or herniated nucleus pulpous on the MRI at the L5-S1 level. Also, the physical examinations demonstrated some weakness in the left extensor hallucis longus which would be in the L4 dermatome distribution which does not correlate to the electrodiagnostic study findings. There was no decreased sensation in the lower extremities noted on the physical examination provided for review in the distribution for the requested procedure. Deep tendon reflexes were normal. Straight leg raising caused back pain only. There was no radiation into the lower extremities. Based on the medical documentation provided for review and the peer- reviewed evidence-based Guidelines the appeal request for an in office lumbar L5-S1 epidural steroid injection under fluoroscopy is denied.

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

The previous adverse determinations are upheld. In order to justify an epidural steroid injection, there needs to be demonstrable radiculopathy both clinically and radiographically. The MRI from 07/25/2013 and physical examination do not demonstrate radiculopathy. Electrodiagnostic studies do not correlate to MRI to support radiculopathy. The electrodiagnostic studies reported bilateral L5 radiculopathy (left greater than right) while physical examination demonstrates findings consistent with L4 radiculopathy. There is no documentation of nerve root impingement or herniated nucleus pulposus on the MRI at the L5-S1 level. There was no decreased sensation in the lower extremities correlating to the corresponding dermatome. Deep tendon reflexes were normal. Straight leg raising pain was limited to the back without radiation into the lower extremities. Without of radiographic and clinical support for radiculopathy, this request for in office epidural steroid injection, at L5-S1 with fluoroscopy for the lumbar spine is non-certified.

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)**