

# CASEREVIEW

8017 Sitka Street  
Fort Worth, TX 76137  
Phone: 817-226-6328  
Fax: 817-612-6558

## Notice of Independent Review Decision

[Date notice sent to all parties]: April 17, 2013

### IRO CASE #:

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

1 Transforaminal Epidural Steroid Injection at the Left L3-L4 under Fluoroscopy between 2/21/2013 and 4/22/2013.

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

This physician is Board Certified in Orthopedic Surgery with over 40 years of experience.

### REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

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:

10/26/12: PT Daily Note (visit 7)  
11/07/12: MRI Lumbar Spine w/o Contrast  
11/14/12: Initial Consultation  
12/19/12: Evaluation  
01/14/13: Follow-up Evaluation  
02/07/13: Medical Records Review  
02/18/13: Follow-up Evaluation  
02/19/13: UR performed  
02/28/13: UR performed  
03/15/13: Follow-up Evaluation

### PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who worked as a xx. On xx/xx/xx, he slipped and fell at work injuring his low back. It was noted in the records that he had previously injured his back in xx/xx while lifting some heavy trashcans that weighed anywhere from 200 to 300 pounds. He was referred for a MRI which reportedly showed some findings, so he was then referred to a surgeon. Due to his claim being denied as a work comp claim, he never received further treatment until he injured it again in xx.

On November 7, 2012, MRI Lumbar Spine, Impression: L5/S1 mild broad-based posterior disc bulge contact the passing S1 nerve roots bilaterally. L3/4 mild focal disc protrusion is seen at the left exit foramen, contacting the exiting left L3 nerve root. L5/S1 disc desiccation.

On November 14, 2012, the claimant was evaluated who reported that after the claimant was injured on xx/xx/xx he was evaluated at xx and had x-rays done. He was treated with medications and underwent 12 sessions of physical therapy. Due to continued symptoms he was referred who ordered an MRI of the lumbar spine. He was then referred for evaluation for steroid injections. The claimant reported he had pain primarily on the left side of the low back that could radiate down the posterior left thigh to just above the knee. He also had complaints of occasional numbness of the entire left leg. It was reported the physical therapy did provide some benefit as he rated his pain initially a 10 and then following therapy an 8. The claimant was off work because his primary care doctor took him off work due to elevated blood sugar running above 200 causing some blurred vision. Past medical history is positive for non-insulin dependent diabetes mellitus, hypertension and hypercholesterolemia. Medications included Ibuprofen 600 mg and Tramadol. On examination he had a tender lumbosacral spine and left paraspinals. No muscle spasms or trigger points noted on exam. Lumbar ROM showed a forward flexion of 25 degrees, extension of 15 degrees, and right and left lateral flexion of 15 degrees, all done with some discomfort. Motor was 5/5 in bilateral low extremities throughout, except for left flexion at 4/5 secondary to pain in the low back limiting full effort. Sensation was subjectively intact to light touch; reflexes were symmetrical 1 to 2+ patella and trace Achilles bilaterally. Negative straight leg raises in the sitting position to 90 degrees. Assessment: 1. Lumbosacral sprain/strain, 2. Disc protrusion L3-4 and L5-S1, 3. Rule out left lower extremity radiculopathy. Recommendations: 1. Continue home exercise program. 2. Continue back precautions and proper lifting techniques. 3. Continue modified duty work release. 4. Continue current medications. 5. Referral for evaluation for steroid injections. However, it was discussed that the claimant's blood sugar had to be under better control in order to do them since steroid injections can elevate the blood sugar.

On December 19, 2012, the claimant was evaluated for back and left leg pain. It was noted that treatments have included physical therapy with minimal improvement, as well as ibuprofen medication. On exam he had significant tenderness in the paraspinal region on the left around the L3-4 and L4-5 area. He had gluteal pain, as well as left sciatic notch pain. There was pain with forward flexion to around 30-40 degrees. He had pain with extension at 5-10

degrees. There was more severe pain with left side bending and rotation. There was positive straight leg raising and Lasegue's on the left. He had low back pain with straight leg raising on the right. Deep tendon reflexes are 2+ patellar and Achilles bilaterally. Sensory to light touch was intact and symmetrical in both lower extremities. There was some mild gastroc soleus weakness on the left at 4+/5 compared to 5/5 strength on the right. Plan: recommended he undergo a transforaminal epidural injection at L3-4 to see how he responds. He felt the claimant may also benefit from an injection at the L5-S1 level on a separate date due to his diabetes. He was sent to his internist to be cleared to proceed with the injection.

On January 14, 2013, the claimant was re-evaluated who reported he was still having some difficulty getting his blood sugars under control; however, they were better presently than they had been in the past. Plan: Follow up on recommendation for transforaminal epidural at L3-4. stated that if the claimant's blood sugars were significantly elevated the morning of the procedure, then he would benefit from a diagnostic nerve root block without any steroid at that level.

On February 18, 2013, the claimant was re-evaluated for continued 70% low back pain on the left paraspinal region with 30% pain radiating down the buttock, posterior thigh, and stopping at the knee. It was reported that his sugars were under much better control, running around 100 at the highest, 110. No change on physical exam. Plan: Send another request for the ESI.

On February 19, 2013, performed a UR. Rationale for Denial: Noted in the records is the patient's diabetes and issues with blood sugar control. Prior records have indicated proposal to perform ESI provided that the patient's blood sugar levels are controlled. The recent report indicated that should the patient's blood sugar are significantly elevated then a diagnostic nerve root block without any steroid would be performed instead of a transforaminal epidural injection. Considering that the request is for an injection that involves the use of steroid (epidural steroid injection), it is prudent that to ensure that the patient's diabetes is in good control prior to performing this injection. The recent records have not shown the patient's diabetes is in good control and that the issue with elevated blood sugar has been addressed. As such, the medical necessity of the requested service has not been substantiated.

On February 28, 2013, performed a UR. Rationale for Denial: No additional medical records were provided for review. The records do not indicate the use of medications to control the claimant's symptoms. Additionally, no indication that the claimant's blood sugar has been controlled prior to performing steroid injection was documented. The Official Disability Guidelines state that unresponsiveness to conservative treatment including exercises, physical therapy, nonsteroidal anti-inflammatory medication, and muscle relaxants should be documented. It is noted that the claimant has undergone 12 sessions of physical therapy, but the use of nonsteroidal anti-inflammatory medication and muscle relaxant medication was not documented. Based on these factors, the appeal request for

transforaminal epidural steroid injection at the left L3-L4 under fluoroscopy is not certified.

On March 15, 2013, the claimant was re-evaluated who noted that the claimant had been taking Tramadol and Voltaren gel and continued to report low back pain with radiating pain to the left buttock, posterior thigh, and knee rated 7-8/10. It was noted that the claimant was unable to tolerate oral anti-inflammatories. He had been recently prescribed Neurontin by his primary physician which had been giving him a little improvement. On physical exam he had positive straight leg raise and indirect straight leg raise on the left. Deep tendon reflexes were 2+ bilaterally. He continued to have some mild gastroc soleus weakness on the left. Plan: Proceed with ESI.

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

The previous adverse determinations are overturned. The claimant meets ODG Criteria for the use of Epidural steroid injections. Objective findings of radiculopathy have been documented including positive SLR test and Lasegue's on the left and mild gastrocnemius-soleus weakness. Radiculopathy was corroborated by MRI findings of focal disc protrusion at the left foramen contacting the exiting left L3 nerve root. Medical records documented that the claimant failed conservative treatment including physical therapy, ibuprofen, Tramadol, and Voltaren gel. It was reported that the claimant was unable to tolerate oral anti-inflammatories. evaluation note dated February 18, 2013 did report that the claimant's blood sugars were under much better control and were running around 100, 110 at the highest. Therefore, seeing that ODG criteria are met and it was documented that the claimant's blood sugars are under control, the request for 1 Transforaminal Epidural Steroid Injection at the Left L3-L4 under Fluoroscopy between 2/21/2013 and 4/22/2013 would 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)**