

Medical Assessments, Inc.

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Notice of Independent Review Decision

[Date notice sent to all parties]: August 19, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

ESI Lumbar L5-S1

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 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:

03/25/2013: MRI Lumbar Spine
05/07/2013: Procedure Note
06/19/2013: Follow-up Office Visit
06/21/2013: Pre-Certification request for Lumbar ESI-2 L5-S1
06/27/2013: UR performed
07/11/2013: Pre-Certification request from for Lumbar ESI-2 L5-S1
07/11/2013: Letter of Reconsideration requesting second Lumbar Epidural steroid injection.
07/23/2013: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was initially injured on xx/xx/xx while at work. Surgical history is positive for lumbar discectomy in September 2011.

03/25/2013: MRI Lumbar Spine interpreted. Impression: Straightening of the lumbar lordosis may be secondary to muscular spasm. 5.1 mm. focal posterocentral L5-S1 disc protrusion/herniation with mild narrowing of the central canal and mild displacement of the descending S1 nerve roots.

05/07/2013: Procedure Note. Postop Diagnosis: Lumbar Displacement, Lumbar Neuritis/Radiculitis, Backache. Procedure: Translaminar ESI – Lumbar – No catheter, Epidurogram/Neurogram, Fluoro Guidance/Localization of Needle or Catheter.

06/19/2013: Follow-up Office Visit. It was reported the claimant got more than 50% relief of pain following lumbar ESI. stated most pain was in her right thigh area, although she did have some in her right ankle area and that a second injection would be worth it to see if they could improve upon her pain relief. On examination there was tenderness of the midline spine and left buttocks. Normal symmetry, tone, strength and ROM. A/O x3, no focal deficits, gait WHL. Diagnosis: Lumbar Displacement, Lumbar Neuritis/Radiculitis, Backache. Plan: Translaminar ESI Lumbar.

06/27/2013: UR performed. Rationale for Denial: MRI dated 01/19/2010 reportedly revealed L5-S1 level disc desiccation, diffuse disc bulge and central disc protrusion producing mild central canal stenosis and mild R neural foramen stenosis. Note dated 04/21/2011 indicates EMG/NCV BLE mild generalized sensorimotor peripheral neuropathy bilat. Evidence acute L5-S1 lumbar radiculopathy. Note dated 07/05/2011 indicates CT myelogram lumbar spine L5-S1 broad based posterior protrusion 7mm lateralizing min to LT w/mild LT lateral recess encroachment and slight underfilling of LT S1 nerve root sleeve, min foraminal encroachment w/o displacement of exiting L5 roots, 7mm disc protrusion significantly larger now as compared to prior min on 02/11/2011 at which time it measured 3mm. The current exam shows some residual myofascial tenderness but no neurologic or radicular findings. Based on the diagnosis and the very chronic nature of the condition and the total lack of evidence of lumbar radiculopathy on exam according to the ODG, the request is not medically necessary.

07/23/2013: UR performed. Rationale for Denial: The claimant's physical examination fails to establish the presence of active lumbar radiculopathy and the submitted MRI fails to document any significant neurocompressive pathology at L5-S1. Prior epidural steroid injection provided 50% pain relief; however, duration of relief is not documented. Based on the review of the medical records provided, the proposed treatment of an ESI Lumbar L5-S1 is not recommended as medically necessary.

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 a Lumbar ESI at L5-S1, physical examination and imaging studies must demonstrate the presence of active radiculopathy and neurocompressive pathology at L5-S1. MRI performed on 03/25/2013 fails to show any neurocompressive pathology and physical examination fails to establish the presence of active lumbar radiculopathy. Although prior epidural steroid injection provided 50% pain relief, there is no documentation of duration of relief. Based on the review of the medical records provided, the proposed treatment of an ESI Lumbar L5- S1 is not recommended as 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)**