

Icon Medical Solutions, Inc.

11815 CR 452
Lindale, TX 75771
P 903.749.4272
F 888.663.6614

Notice of Independent Review Decision

DATE: December 18, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Translaminar Epidural Steroid Injection at L2-L3 (#2)

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

The reviewer is certified by the American Board of Orthopaedic Surgeons with over 40 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:

01/26/11: Lab Results
02/17/11: MRI Lumbar Spine report interpreted
05/09/11: initial Medical Report
05/09/11: Note typed
06/06/11: Peer Review
06/13/11: Independent Medical Examination
08/19/11: Letter of Lab Results
10/26/11: X-Ray Lumbar Spine Report
10/27/11: Orthopedic Consult
11/21/11: Orthopedic Report
01/12/12: Operative Report
01/16/12, 01/23/12: Orthopedic Report
02/07/12: Lumbar Myelogram and Post-Myelogram CT report interpreted
05/10/12, 05/22/12: Orthopedic Report
06/25/12: SNR Operative Report
06/26/12: Peer Review
11/08/12: Orthopedic Report

11/20/12: Procedure Orders
11/27/12: UR performed
11/27/12: Orthopedic Report
12/02/12: Reconsideration Request
12/07/12: Telephone Conference
12/10/12: UR performed

Articles submitted:

Semin Roentgenol. 2004 Jan; 29 (1): 7-23 Epidural Steroid Injections
Spine J. 2004 Sep-Oct; 4 (5): 495-505 The Effect of Spinal Steroid Injections for Degenerative Disc Disease
The Journal of Bone and Joint Surgery (American). 2006; 88: 1722-1725 Nerve Root Blocks in the Treatment of Lumbar Radicular Pain
The Journal of Bone and Joint Surgery (American). 2007; 89 Spinal Disc Arthroplasty: A Road Less Traveled
ODG Epidural Steroid Injections, Therapeutic

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his back and sustained an L2 compression fracture at work on xx/xx/xx. He is status post kyphoplasty, medial branch blocks at L2 and L3, and selective nerve root block on the right at L2.

02/17/11: MRI Lumbar Spine report interpreted. IMPRESSION: L5-S1: Right neural foraminal narrowing. Probable extrinsic compression against the exiting right S1 nerve root sleeve. Mild narrowing of the left neural foramen. Hypertrophic changes of the articular facets. L4-L5: Very high-grade neural foraminal narrowing on the right, less so on the left. Hypertrophic changes of the articular facets, particularly on the left, with fluid in the facet joint. Extrinsic compression against the exiting L5 nerve root sleeves. Annular symmetric bulge of the disc approximately 2 to 3 mm. L3-L4: Very mild neural foraminal narrowing on the right. No central canal stenosis. No significant bulging disc. L2-L3: A 3 mm central broad based bony extradural defect with AP dimension of the central canal 1 cm, lower limits of normal. Extrinsic compression against the exiting right L3 nerve root sleeve. Mild narrowing of the left neural foramen. No definite impingement against the exiting nerve root. Cyst in the right kidney as described. L1-L2: Flattening of the anterior portion of the L2 vertebra, compression fracture, anterior wedge deformity. Loss of anterior vertebral body height, 50%. The age of the compression fracture is unknown. All discs are dehydrated and desiccated.

05/09/11: The claimant was evaluated for a work-related injury. It was noted that he had a compression fracture of the lumbar spine and underwent kyphoplasty. He reported ongoing neck and back pain. On examination, there was tenderness of the lumbar paraspinals bilaterally. Lumbar ranges of motion were restricted. Straight leg raise test was positive. There were no gross sensory or motor changes of the lower extremities. INITIAL DIAGNOSIS: Bulging disc of the lumbar spine. Compression fracture of L2 vertebra. Cervical sprain/strain. TREATMENT PLAN: Flexeril and Naprosyn. Work with restrictions. Follow up in two weeks.

05/09/11: Letter typed. "My complaints are when I get out of bed in the morning, I have persistent and constant pain in my lower back, pain radiating down to my right leg. I constantly have cramping in my right leg during the night. During the day my right leg feels like a tingling and sensitive to touch and a burning sensation down my right leg and lower back area. I cannot turn my body/waist either left or right due to pain. My neck I can barely move it to side to side because of the pain I am in. I constantly have headaches. I am not a diabetic but I have high blood pressure and arthritis on both of my hands. I cannot bend my neck in lower position because of pricking pain and headaches. I have trouble sleeping due to pain. I am presently working part-time with the same company that I have worked for the last 38 years and where I was injured on March 18, 2010. I did not have high blood pressure prior to my accident. I started getting high blood pressure after the accident because of the pain I am presently having due to my fall."

06/06/11: Peer Review. "There is no additional active treatment reasonably required as related to the work event sustained on 03/18/10. It is more probable than not that any ongoing symptoms in the claimant at this time are not causally related to the work event or resultant surgery, but rather due to other disease of life findings. The neurosurgeon reported this opinion on 06/10/10. It is probable that the effects of the work event with resultant kyphoplasty at L2 has resolved and any ongoing thoracolumbar complaints are not related to the 03/18/10 work event.

06/13/11: Independent Medical Examination. "The patient states that he is currently receiving no treatment. The documentation indicates that the patient has received all necessary treatments indicated for his injury as per the Official Disability Guidelines. He has reached the plateau and was placed at MMI as of June 24, 2010. His current symptoms are probably due to his preexisting spondylosis; although, myofascial pain component is likely to be present as well. The patient is not a candidate for further interventions since they are not likely to benefit him. This includes office visits, prescription medications, physical therapy, chiropractic treatments, spinal injections, invasive procedures, DME, or surgery. The patient's condition is compatible with release to home exercise program and continued use of over-the-counter medications as needed. The patient is not a candidate for further interventions, nor would such interventions be supported by the Official Disability Guidelines. As for medications, over-the-counter analgesics and/or over-the-counter non-steroidal anti-inflammatory drugs would be reasonable and appropriate. As for DME, none is indicated nor supported by Official Disability Guidelines. In regard to diagnostic studies, they should be performed on an as needed basis in case of significant clinical deterioration. As for office visits, there is no indication for regular office visits at this time, and the patient could be seen on an as needed basis."

10/26/11: X-Ray Lumbar Spine report interpreted. IMPRESSION: Kyphoplasty L2.

10/27/11: The claimant was evaluated. It was noted that he underwent an L2 kyphoplasty on 03/22/10. He presented with low back pain rated 8/10. On exam, he was uncomfortable and had difficulty getting out of the chair and onto the examination table. He had tenderness over his right and left paravertebral areas with decreased range of motion with flexion and extension. His motor strength and sensation were intact in his lower extremities. His reflexes were 2+ at the patellae and Achilles. Straight leg raises were positive for back pain only. His gait was unremarkable. He was able to heel-to-toe walk, walk on toes, and walk on heels with discomfort in his low back. X-rays revealed a burst fracture of L2 with intervertebral cement. MRI revealed hypertrophy of the articular facets bilaterally at L2-L3. PLAN: With regard to the patient's lumbar spine, he continues to remain symptomatic. He had tenderness around his L2-L3 facets bilaterally. He has no lower extremity symptoms present on physical examination. We believe the patient would benefit from a medial branch block at his right and left L2 and L3 facet. We are requesting a medial branch block at his bilateral L2-L3 levels. If the patient does well following his injection, he would be a candidate for a radiofrequency ablation at those particular levels. Procedure, risks, and benefits were discussed with the patient and informative handouts were given. We will proceed once authorized by his insurance carrier.

01/12/12: Operative Report. Post-Operative Diagnosis: Lumbar facet strain/syndrome. PROCEDURES: Lumbar medial branch block L2 facet nerve right. Lumbar medial branch block L3 facet nerve right. Fluoroscopic localization needle, lumbar.

01/16/12: notes that the claimant had a right L2 facet nerve medial branch block and a right L3 facet nerve medial branch block performed on 01/12/12 and that he did not have much improvement. He noted that his MRI showed foraminal stenosis on the right. He had paresthesias and numbness in the right thigh area and a positive femoral stretch. believed that some of those findings may have been present before but may have been overlooked. He stated that, based on the injection, he did not feel that the claimant's pain was coming from his facets but rather from foraminal stenosis. He recommended getting a CT myelogram of the lumbar spine.

01/23/12: The claimant was reevaluated. It was noted that he had very little relief following his medial branch block. He presented with low back pain rated at 7/10 with constant pain in the back area, discomfort with side-to-side movement, soreness, and stiffness. He had pain that radiated to his bilateral lower extremities, right side greater than left. On exam, there was tenderness on his mid to lower lumbar region with decreased range of motion with flexion and extension. His motor strength remained intact. He had mild paresthesias in the lateral aspects of both lower extremities. He had a positive femoral stretch test on the right, negative on the left. PLAN: The patient continues to remain symptomatic. He has exhausted physical therapy and oral anti-inflammatories as well as a diagnostic medial branch block with very little relief. At this time, we are requesting a CT myelogram to evaluate his foraminal stenosis at L2-L3 on the

right. This will be a preoperative planning tool. We will see him back following this study to review his results.

02/07/12: Lumbar Myelogram and Post-Myelogram CT report interpreted. IMPRESSION: L2 shows moderately severe axial compression deformity with vertebroplasty. Retropulsion of the posterior vertebral border by 2-3 mm. Undulation of the anterior contrast column at all lumbar levels 2-3 mm suggesting diffuse annular bulges. Slightly reduced filling of the left L3 and right L5 roots at the interspace levels. Multilevel spondylosis. L4-L5 shows diffuse annular bulge lateralizing to the right with reduced filling of the L5 root. L1 shows an unusual appearance on the right which could represent a congenital anomaly versus transverse process fracture nonunion.

05/10/12: The claimant was reevaluated. It was noted that following his CT myelogram, he had a heart attack. He underwent placement of stents into his heart. On 05/10/12, he presented with back pain rated at 8/10 that radiated to his right hip and thigh areas. On examination, there was tenderness in the lumbar spine with decreased range of motion with flexion and extension. He had paresthesias around his hip and thigh areas. He had a positive femoral stretch test on his right, negative on his left. CT myelogram revealed retropulsion of the posterior vertebral border causing some stenosis at the L2-L3 level. PLAN: At this point, after reviewing the CT myelogram as well as the patient's physical examination findings, we believe he is having some stenosis at his L2 nerve root on the right. We are recommending a selective nerve root block at his right L2. Depending on how the patient does with the block, we may consider surgical intervention. The patient was advised to follow with his cardiologist regarding his heart attack. We will not be performing any type of surgery within the year following his heart attack. Hopefully the injection will help with his right lower extremity symptoms. We will proceed once authorized by his insurance carrier.

06/25/12: SNR Operative Report. Postoperative Diagnosis: Lumbar radiculopathy. Procedures: Lumbar selective nerve block L2 right. Interpretation of lumbar epidurogram. Fluoroscopic localization of needle, lumbar.

11/08/12: The claimant was reevaluated. It was noted that he stated while the local anesthetic was in effect following his selective nerve block at L2, he was having 70-80% relief; however, he missed his postoperative visit due to suffering a heart attack in April 2012 and having a lot going on around June. It was noted that office was moved on 07/01/12, and the claimant was not informed of the move. On the 11/08/12 visit, he complained of 6/10 back pain which radiated to the right hip and thigh. On exam, he had tenderness in the lumbar spine with decreased range of motion. He had paresthesias along the right L2 distribution. PLAN: Based on the patient's response to the selective nerve root block on the right, there is clearly something going on with that nerve root. I believe that at some point, we may want to do a surgical treatment for that radiculopathy. However, because the patient had a myocardial infarction six months ago, he is not a candidate for elective surgery. As a result, I recommend a Translaminar lumbar epidural injection at L2-L3. This should help alleviate some of his pain

while we wait for an appropriate window for surgical intervention. I would like the patient to receive some additional physical therapy in conjunction with the epidural injection. I recommend getting lower extremity electrodiagnostic studies to evaluate his radiculopathy. Approximately one year after the patient's MI, we may consider a lumbar laminectomy and foraminotomy.

11/27/12: UR performed. RATIONALE: Official Disability Guideline Low Back Chapter on epidural steroid injections recommend the treatment when radiculopathy is objectively documented on a physical examination and corroborated by imaging studies. In the claimant's case, his symptoms as reported are nonspecific. Additionally, the physical examination reveals no objective evidence of L2 radiculopathy. Finally, the claimant's MRI as reported on 02/17/11 reveals no definite impingement against the exiting nerve root L2. Finally, the 02/07/12 CT myelogram shows no deformity or compression of the L2 nerve root at L2-L3 but states slightly reduced feeling of the left L3 root, the root which is not in question in this case. Taking the aforementioned factors of the claimant's case into consideration where there is no convincing symptomatic or objective evidence of L2 radiculopathy, and imaging studies as noted above which reveal no compression of the exiting L2 nerve root at L2-L3, the request for a translaminar epidural steroid injection at L2-L3 number two cannot be considered medically necessary.

11/27/12: reviewed the denial letter regarding the recommended translaminar lumbar epidural steroid injection at L2-L3. In response dispute of the MRI findings and physical exam revealing no sensory deficit with respect to L2, stated that it was noted on 05/10/12 that the claimant had paresthesias around his hip and thigh areas anteriorly to laterally following the L2 distribution pattern and that he complained of persistent hip and back pain, more so on the right side. He noted that MRI indicated there was some extrinsic compression against the exiting right L5 nerve root, but it also did explain on his personal review that there was compression deformity noted at L2 vertebra with right foraminal stenosis at L2-L3 upon the exiting L2 nerve root. stated that his MRI from 02/17/11 revealed a 3-mm bony extradural defect projecting into the canal portion but that he did not believe it was a bony extradural defect. He believed it was a disc going to that particular area and that CT myelogram revealed more of an issue around the left L3 nerve root. He stated that he believed that most of the information that reveals the claimant's symptoms were coming from his L2-L3 area are seen on his lumbar MRI dated 02/17/11. He wanted to proceed with a second right L2 nerve block.

12/10/12: UR performed. RATIONALE: Additional documentation provided includes the appeal letter from the treating provider from 11/27/12. The request is not certified based on the documentation provided. The claimant reportedly had a prior lumbar selective nerve root block performed; however, did not followup immediately post injection due to other medical illnesses. There is no objective documentation that the claimant had improvement from the previous injection; although, an initial improvement was reported. There is no documentation of decreased medication use of increased function or decreased pain scores. The guidelines would not support repeat injection without documentation of at least 50-

70% pain relief for 6-8 weeks on examination. True objective radiculopathy has not been noted on the most recent examination provided for review. Evidence of muscular weakness, loss of reflex, decreased sensation in a dermatomal distribution has not been documented. Nerve root impingement has not solely been indicated on the diagnostic imaging, and electrodiagnostic studies were recently recommended but not provided for review or performed. Without true objective evidence of radiculopathy and documentation of objective improvement from previous injection, the request would not be supported at this time.

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

The previous adverse decisions are upheld. After reviewing his records, I would agree with the denial of the procedure. I agree with assessment of the claimant. He has had a prior selective nerve block. He did not followup postop and did not have any significant long-term relief. There is no objective documentation that he had significant improvement from previous injections of this nature. There is no indication that his symptoms changed significantly. There are no true objective radiculopathy findings that would be related to the L2 or L3 nerve root. It appears that his pain involves his entire back and neck, and a selective nerve block would not likely improve his symptoms. Therefore, the request for Translaminar Epidural Steroid Injection at L2-L3 (#2) is not medically necessary and is non-certified.

<p>Epidural steroid injections (ESIs), therapeutic</p>	<p>Criteria for the use of Epidural steroid injections: <i>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.</i></p> <p>(1) Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.</p> <p>(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).</p> <p>(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.</p> <p>(4) <i>Diagnostic Phase:</i> 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.</p> <p>(5) No more than two nerve root levels should be injected using transforaminal blocks.</p> <p>(6) No more than one interlaminar level should be injected at one session.</p> <p>(7) <i>Therapeutic phase:</i> 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)</p>
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	<p>(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.</p> <p>(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.</p> <p>(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.</p> <p>(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.)</p>
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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)