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Notice of Independent Review Decision

DATE: July 17, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral Transforaminal ESI at L3-L4, L4-L5 (second injection)

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 Anesthesiology with secondary practice in the area of Pain Management with 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:

07/20/11: MRI Lumbar Spine report
02/18/13: New Patient Consult
03/18/13, 06/03/13: Followup visit
04/17/13: Followup
05/14/13: Procedure Note
06/07/13: Preauthorization request
06/12/13: UR performed
06/13/13: Appeal request
06/17/13: UR performed
06/28/13: Pain Management phone message

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his low back while working on xx/xx/xx. He is status post one lumbar epidural steroid injection performed on May 14, 2013, physical therapy, and use of massage/TENS unit.

07/20/11: MRI Lumbar Spine report. IMPRESSION: At L3-L4, a 4.0 mm subligamentous disc extrusion is seen with a radial tear in the outer annulus flattening the thecal sac with mild bilateral foraminal narrowing. At L4-L5, flattening of the thecal sac with mild bilateral foraminal encroachment is present. At L5-S1, a 3.0 mm subligamentous disc protrusion flattens the thecal sac with mild bilateral foraminal encroachment.

02/18/13: The claimant was evaluated for low back pain radiating down bilateral legs. The pain was described as aching, dull, numbness in bilateral legs, sharp, shooting, stabbing, throbbing, and tightness. The pain was rated 8/10. The pain improved with rest and worsened while walking, with activity, with range of motion, while sitting, and with standing. It was noted that with physical therapy, pain relief was moderate. His medications included Ambien, ibuprofen, and Tramadol. On exam, he had decreased lumbar range of motion. He had diminished strength and tone due to pain. Sensation was intact. There were no fasciculations, gait abnormality, or limp. He was prescribed gabapentin and instructed to return to the clinic in one month.

03/18/13: The claimant was evaluated for low back pain rated at 8/10. It was noted that the pain radiated into the "lower extremity – bilateral foot." On exam, there were no changes from exam of 02/18/13. It was noted that he continued to defer ESI at the time of visit. He was to return in one month.

04/17/13: The claimant was evaluated for low back pain rated at 8/10. He complained of limitation of activity, limitation of back movement, pain with cause, stiffness, and tenderness in the back. In the joints, he complained of aching, limitation of joint movement, morning stiffness, and tenderness. He complained of muscle aches, cramps with exertion, limitation of activity, and limitation of movement. On exam, he had decreased lumbar range of motion. Paravertebral muscle spasm was noted and tenderness in the midline. On inspection, there were muscle spasms at bilateral iliocostalis lumborum. Straight leg sign was abnormal. He was given a prescription for Norco. discussed injection therapy. He stopped his Neurontin due to side effects. It was noted that the claimant was having radicular pain unresponsive to conventional treatments such as physical therapy, rehabilitation, and the use of medication for more than four weeks.

05/14/13: Procedure note. POSTOPERATIVE DIAGNOSIS: Lumbosacral neuritis or radiculitis unspecified. Lumbosacral root lesions not elsewhere classified. Spinal stenosis of lumbar region. Displacement of lumbar intervertebral disc without myelopathy. PROCEDURE PERFORMED: Lumbar transforaminal ESI L3-L4 and L4-L5, bilateral; lumbar fluoroscopy, epidurogram with interpretation.

06/03/13: The claimant was evaluated for injection followup. It was noted that he gained 60% relief. His pain was rated 6/10. On exam, he had paravertebral muscle spasm and tenderness in the midline. Range of motion was decreased in the lumbar spine. Straight leg sign was abnormal. He was given a prescription for Norco and request was made for a second injection for pain control.

06/12/13: UR performed. CONCLUSION: The L4-L5 level on MRI showed only a bulge but no overt HNP, extrusion, or nerve impingement. So, and ESI at this level is not supported as per ODG. The MD claims a prior TFE helped 60%, but there is no indication when this was done or the duration of the relief it provided. Until that is documented to verify a therapeutic result, the repeat TFE is not indicated.

06/17/13: UR performed. CONCLUSION: The initial request was non-certified noting that the L4-L5 level on MRI showed only a bulge but no overt HNP, extrusion, or nerve impingement so an epidural steroid injection at this level is not supported as per ODG. The MD claims prior TFE helped 60%, but there is no indication when this was done or the duration of relief it provided. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The above issues have not been addressed. It remains unclear when the prior epidural steroid injection was performed, and therefore, duration of relief cannot be determined. Peer to peer was unsuccessful.

06/28/13: Phone message noted: PT complaining of pain, saw PA on 6/27 and was requesting stronger pain med.

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

The previous adverse decisions are upheld. On June 3, 2013, PA, reports "60% pain relief" from injection, not listing when, where, or for how long the pain relief occurred. If the pain relief was only during the time that the local anesthetic was in effect, it is a significant different entity than if the pain relief occurred early and continued. He also reports that "his pain is at 6/10". Since the initial pain was "8/10", this is a 25% pain relief, an entirely different situation than a 60% pain relief. One would assume the latter since the claimant had considerable abnormal signs and symptoms on the physical evaluation on June 3, 2013. As noted by the previous UR reviewers, the lumbar spine MRI performed, on July 20, 2011, indicated a bulge rather than a protrusion at L4-L5. By ODG recommendations, a lumbar epidural steroid injection is not indicated at this level for a bulge. Lastly, the compensable injury is stated to have occurred on xx/xx/xx. The interim medical history between the MRI and the February 18, 2013 initial evaluation is not given, including no mention of medications, treatment, or symptomatology. Assuming that no significant treatment occurred, it is highly unlikely that an isolated lumbar epidural steroid injection or a series of lumbar epidural steroid injections nearly two years after the injury would have significant beneficial effects to justify the use of this invasive procedure. Therefore, the request for Bilateral Transforaminal ESI at L3-L4, L4-L5 (second injection) is not medically necessary and is non certified.

ODG:

<p>Epidural steroid injections (ESIs), therapeutic</p>	<p>Criteria for the use of Epidural steroid injections:</p> <p><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> <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)**