CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: July 8, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar Epidural Steroid Injection L4-5

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a Board Certified Neurosurgeon with over 45 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:
12/08/11: Lumbar Spine MRI
01/17/12: Peer Review
02/07/12: Progress Note
05/17/12: Progress Note
05/25/12: Initial Visit
05/31/12: Re-read 12/8/11 MRI
06/01/12: Follow-up Evaluation
06/29/12: Follow-up Evaluation
03/06/13: Follow-up Evaluation
03/27/13: Follow-up Evaluation
04/04/13: UR performed
04/07/13: Letter
04/18/13: Follow-up Evaluation
05/22/13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who was injured on xx/xx/xx when she dropped a xx.

On December 8, 2011, Lumbar Spine MRI, Impression: 1. An 18 x 11 x 8mm complicated synovial cyst versus ganglion severely narrows the left lateral recess. Superimposed L4-5 spondylosis annular disc bulging, bilateral ligament flava hypertrophy and bilateral facet osteoarthritis are also seen. 2. The spinal canal at L4-5 is severely stenotic. The traversing L5 nerve roots are contacted, left worse than right. The L4-5 neural foramina mildly encroached without compressing the exiting L4 nerve root sheaths. 3. No significant canal stenosis at L1-2, L2-3, L3-4, or L5-S1 is seen. 4. Minimal L4-5 and L5-S1 degenerative retrolisthesis are noted.

On February 7, 2012, the claimant was evaluated for pain in the low back that radiated to the lateral aspect of the right leg. It was reported that she was post transforaminal epidural steroid injection right L4 and L5 and she was 60% improved. On physical examination there was tenderness to palpation of spinous process L4-L5, no facet tenderness, no pain with facet loading. Right straight leg raise was positive. Mildly reduced lumbar spine range of motion and pain with flexion. Right lower extremity strength showed quadriceps weakness present. DTRs were equal and symmetrical throughout lower extremities. Assessment: 1. Back pain with radiation. 2. Displacement of thoracic or lumbar intervertebral disc without myelopathy; lumbar intervertebral disc without myelopathy. Plan: She was doing much better but continued to have symptoms and was waking up with spasms in her right leg and toes. Given that, recommended proceeding with a right transforaminal ESI at L4, L5.

On May 17, 2012, the claimant was evaluated on physical examination no palpable bony or muscular tenderness, normal gait, good toe/heel walk, DTRS equal, sensory intact to light touch, motor 5/5 and negative straight leg raising. Assessment: 1. Lumbar radiculopathy. 2. Lumbar strain. 3. Lumbar disc degeneration. 4. Lumbar synovial cyst. Plan: Surgical Intervention.

On May 25, 2012, the claimant was evaluation for constant low back pain that is described as dull and achy and increase with activity, standing, bending forward, bending backwards and walking. On examination there was no tenderness or spasm to palpation. Range of motion was limited in flexion, extension and lateral tilting. Straight leg raising does reproduce radiculopathy, in the right more than the left. No atrophy or sensory changes. Dorsiflexors and evertors were 4/5 in the right. Deep tendon reflexes were hypoactive in the patellar, right more than left. wanted to review the MRI.

On May 31, 2012, read the Lumbar MRI performed 12/8/11. Findings: L4-5 has mild narrowing of the interspace and mild desiccation. Moderate facet arthrosis bilaterally. Slight bulge of the disc. Marked thickening of the yellow ligaments bilaterally. Moderate narrowing of the neural foramina bilaterally. Soft tissue mass present medial to the yellow ligament going from posterior to anterior all the

way to the level of the neural foramina on the right. There is a suggestion of some increased signal at the level of the neural foramina on the right side on the T1 weighted images. There is mild narrowing on the left side of the neural foramina, as well. On the sagittal sequences there is evidence of a posterior lesion toward the right, which would be in favor of a synovial cyst. The possibility of some discal fragments cannot be ruled out. L5-S1 has mild narrowing and desiccation of the disc with mild facet arthrosis bilaterally.

On June 1, 2012 and June 29, 2012, the claimant was re-evaluated who prescribed Ultram 50 mg and Caudal LES L4-5 and Transforaminal right L4-5.

On March 6, 2013, the claimant was re-evaluated for recurrent sharp and aching pain in her lower back with radiation into her right leg. Her pain level is 7/10. She had numbness, tingling and weakness in her right leg and foot. It was reported she had suffered severe medical issues including thyroid problems last year with caused her to not be able to take care of her lumbar spine problems. She was stable, but recently had a very significant aggravation of her pain and radiculopathy going into the right lower extremity. It was also noted she had not been taking any medication regularly. On physical examination no atrophy noted, motor strength was 5/5 in the lower extremities, and sensory exam was normal. Deep tendon reflexes were normoactive. Range of motion was limited in flexion, extension and lateral tilting. On palpation there was evidence of tenderness and spasm. Straight leg raising reproduced radiculopathy. Medications: Ultram 50 mg, Daypro 600 mg, and Flexeril 5 mg. Plan: It was recommended she continue her home exercise program and start taking Ultram 50 mg and Daypro 600 mg.

On March 27, 2013, the claimant was re-evaluated who noted the claimant stated the pain had been extremely severe and she didn't feel that she could tolerate it anymore, particularly with the radiculopathy toward the right. She was now ready to attempt an epidural steroid injection. She also did not want to take anything stronger than the Tramadol she was already taking, therefore, advised her to stop the Daypro. No change on physical examination. Impression & Recommendations: 1. Stenosis, lumbar spine. 2. Synovial Cyst. Recommendations regarding care of the spine include weight loss, exercises, activities to avoid and usage and risk of medication were given.

On April 4, 2013, performed a UR. Rationale for Denial: The MRI showed facet arthrosis at L4/5 with bulge causing L4 and L5 root impingement b/l. The patient had an ESI in 1/2012 with "partial relief" but no further details given. The patient was seen 6/2012 and had noted right foot weakness and a right SLR. On 3/16/13 she had a right SLR. On 3/27/13, she had reduced right patellar and Achilles DTRs. The MD wants to do a caudal and facet injection. The MD could not quantify the prior ESI result and the PCP note of 5/2012 never mentioned it and even stated the patient needed surgery which would indicate the injection had failed to be therapeutic.

On April 7, 2013, wrote a letter indicating the DO misrepresented the details of their conversation in her notice of adverse determination. noted she put forth the

opinion that she did not know why a synovial cyst needs to be ruptured. This is elementary knowledge for anybody who works with the spine. She felt this was not usual and customary treatment. clarified in the letter that the role of the injection through the facet is to attempt to rupture the cyst in the hope that surgery can be avoided.

On April 18, 2013, the claimant was re-evaluated for complaints of chronic sharp, aching and burning pain in her lower back with radiation into her right leg. He pain level was 7/10 with numbness and tingling in her right leg and foot with weakness in her leg. On examination gait was normal, sensory exam was normal and no atrophy. Motor strength was 4/5 weakness of the dorsiflexors in the right. Deep tendon reflexes were hypoactive in the right patellar. Changing from sitting to standing position was done with mild difficulty. Range of motion was limited in flexion, extension, and lateral tilting. There was evidence of tenderness and spasm to palpation. Tiptoe and heel walking were well done. Straight leg raising does reproduce radiculopathy. Impression & Recommendations: 1. Stenosis, lumbar spine. 2. Synovial cyst. It was noted that initial denied authorization for the lumbar epidural steroid injection and the facet injection. Then, they changed their position and gave authorization for the facet injection for the synovial cyst. After that was done, during a conversation with the adjuster, the adjuster said that they did not accept anything as a compensable injury besides a sprain. stated it was unfortunate that the insurance company continues to require the claimant to suffer with her symptoms of radiculopathy. Hopefully, these could be improved with an injection, however, she may eventually require a decompressive procedure for the symptoms which were triggered by the compensable injury.

On May 22, 2013, performed a UR. Rationale for Denial: “The MD could not quantify the prior ESI result and the PCP note of May 2012 never mentioned it and even stated the patient needed surgery which would indicate this injection had failed to be therapeutic.” For this reason, an additional injection may not be effective. Furthermore, the request does not meet guideline #4.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse determinations are overturned. Official Disability Guidelines criteria for the use of ESIs include objective findings of radiculopathy on examination need to be present and corroborated by imaging studies. On April 18, 2013, reported the claimant had complaints of chronic sharp, aching and burning pain in her lower back with radiation into her right leg. Her pain level was recorded as 7/10 with numbness and tingling in her right leg and foot with weakness in her leg. On physical examination he documented motor strength was 4/5 weakness of the dorsiflexors in the right, deep tendon reflexes were hypoactive in the right patellar, and straight leg raising reproduced radiculopathy. These objective clinical findings of radiculopathy are corroborated by the MRI performed on December 8, 2011.

ODG criteria also includes that if an initial block is given and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks

may be supported. The claimant underwent an initial ESI in January 2012. reported on February 7, 2012 that the claimant had 60% relief following the right L4-L5 transforaminal ESI. A second ESI was recommended, however, due to other severe medical issues, the claimant's treatment for the lumbar injury were suspended until March of 2013 when the claimant suffered an increase in pain and radicular symptoms. The request for Lumbar Epidural Steroid Injection L4-5 meets ODG criteria and therefore is found to be medically necessary and is approved.

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)**