

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: March 6, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar ESI (#2)

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

This physician is Board Certified in 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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx-year-old female who was injured on xxxxxx. While working as a xxxx at a xxxx xxx, she tripped over a rolling dolly and fell backward hitting her tailbone and her head. She presented to the ER with severe pain, weakness in the left leg with poor balance and a complaint of transient urinary incontinence, mild. A CT scan was performed of her head, cervical spine, thoracic spine, and

lumbar spine. She was given medications and discharged. She presented to Dr. on October 19, 2012 for continuation of treatment.

On October 19, 2012, the claimant was evaluated by, MD for back pain and complaints of loss of some bladder control. Her current medications were listed as Hydrocodone 7.5-500mg, Ondansetron 4mg, Norco 10-325mg and Flexeril 10 mg. On physical examination she was sitting uncomfortably and had difficulty acquiring a full, upright position when getting out of the chair. She had an antalgic gait to the left. She used a cane for assistance with ambulation secondary to left leg weakness. Right quadriceps strength was 5. Left quadriceps strength was 4. Right tib anterior strength was 5. Left tib anterior strength was 4. Right EHL/Peroneus strength was 5. Left EHL/Peroneus strength was 4. Right Gastro-Soleus strength was 5. Left Gastro-Soleus strength was 4. There was also paresthesia of the left lower extremity in the L5 distribution. X-rays revealed L4-L5 spondylolisthesis, no significant scoliosis and pump from laparoscopic band was visible. Diagnosis: L4-5 spondylolisthesis and lumbar radicular syndrome. Plan: Physical therapy, MRI lumbar spine, neurology consult for post concussive syndrome, prescription for Hydrocodone and Flexeril. Return following MRI, if no improvement, may need ESI.

On October 30, 2012, MRI of the Lumbar Spine, Impression: Degenerative grade I spondylolisthesis of L4 on L5 with 4-mm broad-based posterior disk protrusion and ligamentum flavum hypertrophy narrowing the central canal to approximately 8 mm. Mild right and moderate left neural foraminal narrowing is identified.

On November 8, 2012, the claimant was re-evaluated by, MD for continued severe low back pain and left leg pain. The claimant continued to utilize a cane for assistance with ambulation. On exam, 5/5 strength right lower extremity, and 4/5 strength left anterior tibialis and extensor hallucis longus. Plan: Lumbar ESI and physical therapy along with continuation of Hydrocodone and Flexeril.

On December 7, 2012, Operative Report by, MD, Postoperative Diagnosis: L4-5 spondylolisthesis. Procedures: 1. Caudal epidural steroid injection. 2. Caudal intraspinal myelography without dural puncture. 3. Myelographic interpretation, no radiologist present.

On January 31, 2013, the claimant was re-evaluated by, MD and was reported to still feel left leg pain and weakness. It was reported her pain occurs daily causing decreased physical activity. She reported falling secondary to weakness and pain

and was taking Hydrocodone daily. On exam strength was 4/5 of the left anterior tibialis and extensor hallucis longus. There was paresthesia in the left L5 distribution. Plan: ESI lumbar #2, indication for steroid injection is continued leg pain and weakness.

On February 7, 2013, , MD performed a UR. Rationale for Denial: At the present time, for the described medical situation, the above noted reference would not support this specific request to be one of medical necessity. The above noted reference would not presently support this request to be one of medical necessity, as the submitted documentation does not provide any data to indicate that there was a previous significant positive response to a recent attempt at lumbar epidural steroid injection. As a result, presently, medical necessity for this request is not currently established.

On February 15, 2013, , DO performed a UR. Rationale for Denial: There is no result given for the first ESI done on 12/7/12. The office admitted this as well. There is also no updated physical examination. There is no historical or clinical support for a repeat ESI. Peer to Peer discussion was unsuccessful.

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

The previous adverse determinations are upheld. Based on the information provided for review, there is not enough evidence to substantiate a need for a second ESI. Per ODG, there needs to be documentation of significant positive response to the first ESI to justify a repeat procedure. There lacks documentation of a reduction in pain of 50-70% or greater to justify the second ESI. Post primary procedure the claimant continued to report leg pain and weakness and continued need for pharmacologic therapy. Therefore, the previous denial is upheld and the current request for Lumbar ESI (#2) is non-certified.

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)**