

AccuReview

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Notice of Independent Review Decision

[Date notice sent to all parties]: April 1, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Spine Epidural Steroidal Injection @ L4-5 62311 77003

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

This physician is Board Certified in Rehabilitation and Physical Medicine with over 18 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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained injuries to multiple body parts on xx/xx/xx secondary to a motor vehicle accident. A request was made for lumbar ESI at L4-5. Following the accident, the claimant experienced pain in his lower back that radiated to his right hip, thigh and knee, as well as weakness in his leg which caused him to fall.

01-05-13: Neck Index Score. Total Neck Index Score: 38.

08-28-13: Lumbar Spine, 3 Views. Impression: No acute bony abnormality. Trivial disc space narrowing at L4-L5.

09-04-13: MRI Lumbar Spine W/O Contrast. Impression: Early degenerative disc disease at L4-5 and L5-S1. There are small disc extrusions at each of these levels. There is no resultant central canal stenosis or foraminal stenosis.

09-26-13: Initial Evaluation. Diagnosis: Stenosis with Radiculitis, Cervicalgia/Lumbago. Claimant's pain indicates right neurogenic facetox, likely secondary to foraminal stenosis of carrying factors. Right LE radiculitis is lumbosacral dermatomes L5-S3. Back Index Score: 56, Neck Index Score: 54. Plan of care: Skilled PT intervention for 2 x a week for 12-18 sessions as indicated pending patient compliance.

10-16-13: Office Visit. Claimant complained of increased LBP. PE: Musculoskeletal: normal. Discussed OTC medications. Diagnoses: 723.1 Cervicalgia, 724.2 Lumbago, 724.3 Sciatica, 842.01 Sprain of carpal (joint) of wrist. Medications: prednisone 10mg, Tramadol Hcl 50mg.

11-04-13: Office Visit. Chief complaint: neck and upper back pain. PE: Musculoskeletal: normal. Continue therapy and follow up in 2 weeks for evaluation and treatment. Toradol 30mg IM given. DX Codes: 723.1 Cervicalgia, 724.2 Lumbago, 724.3 Sciatica, 842.01 Sprain of carpal (joint) of wrist. Medications: Diclofenac Sodium 75mg, prednisone 10mg, Tramadol 50mg.

11-05-13: Back Index Score. Back Index Score: 42.

11-10-13: Reevaluation/Progress Note. Requesting extended skilled intervention. Claimant has attempted 6 sessions for training and progression into lumbopelvic/cervicocranial decompression/stabilization program. ROM cervical: R/L: 25/20; MMT shldabd: R/L: 5/5, 4/5 (sporadic for painful limitation). Assessment: claimant has made notable progress, pain goal has been met for short term. His adherence goals have improved for plan of care. LTG has not been met: pain/pt straight & ROM partially met, continues to have consistent painful inhibition/functional tolerance rating have improved but not tolerated to goal level. Neck & back index have improved but not to goal level. Treatment plan: will request continued payot authorization for 2x week for 4 weeks (8 sessions).

12-09-13: Physical Therapy Progress Note. Claimant reported significant increase pain in right hand/UE since midnight, stated he never glide stretching and tried to keep elbow straight versus bent. HE reported cervical/thoracic pain is better and had improved since starting therapy and lumbar pain only with bending over, but constant right LE pain. Reported compliant with restrictions, pain 8/10, constant, hot sensation, burning sensation in hand, hand feels bruised, unbearable pain. Displayed AROM lumbar flex/ext 56/17, lumbar R lateral flexion 22 and L lateral flexion 20. During manual muscle testing, claimant has pain in right side lumbar with all the following testing: right hip flexion/ext/abd/add and quadriceps/hams along with shakiness with left hip flexion. Claimant presented with pain patterns that were inconsistent to typical musculoskeletal patterns; pain in anterior thigh with knee extension. Claimant presented with multiple problems

involving the cervical with right UE nerve pain, thoracic left now versus the right side and lumbar with right LE nerve pain. Claimant has good rehab potential and would benefit from skilled PT services to address muscle flexibility, abdominal weakness, thoracic paraspinal muscle spasms, postural deficits, cervical radiculopathy with right UE involvement and lumbar/thoracic/cervical pain management in order to perform work-related activities and functional activities with less difficulty. Recommend MRI of cervical/thoracic/lumbar spine and EMG study right UE and LE as well as consultation with neurosurgeon/spinal specialist.

12-09-13: PT Lumbar/Lower Extremity Eval. Past Medical Hx: musculoskeletal: chronic low back pain, other (chronic cervical pain). PT Lumbar /Lower Ext: Objective: Lumbar ROM: Lumbar flexion: active (25 degrees; increased L3 pain; 16 inches fingers to floor); lumbar extension: active (5 degrees; R side lumbar pain); Lt lat bending: active (5 degrees increased R side lumbar pain); Rt lat bending: active (4 degrees; popping in lumbar spine pain); Lt rotation: active (40 degrees; tolerable pain); Rt rotation: active (40 degrees; audible crepitus). Lumbar tests: bilateral: PT lumbar tests: b hip flexors tightness (R more involved than L), supine SLR (muscle stretch on L; pain in quadriceps on R), Spring test (tenderness in C4-C7 and T7-L5; decreased movement in vertebrae). Assessment: Claimant presented with an increase in central lumbar pain with prone position on elbows and with double knees to chest position; double knee to chest also caused increased pain in lower abdominals and R hip. Pt experienced muscle tightness/lumbar pain with lumbar flexion/extension/side bending bilaterally/rotation bilaterally, with R side more involved than the L. Claimant experienced an increase in R lumbar pain with the quadratus lumborum manual muscle test on the R and the L; indicating increased muscle stiffness and muscle spasm bilaterally. Recommendation: rehab potential: good. Problems identified: decreased ability w/ADL's, difficulty (with work-related and functional activities), decreased endurance, and decreased ROM, decreased strength, pain. Skilled PT recommended: yes.

01-20-14: Physical Therapy Daily Note. Assessment: Claimant reassessment of lumbar, thoracic and cervical spine. Performed manual therapy to cervical to alleviate neurological symptoms and pain. Tenderness upon palpation to lumbosacral spinous process L4-S2. Modifications and changes to exercises due to claimant's symptoms and working towards neurological deficits in right LE, L3 and right UE, median nerve burning sensations. Limitations to advance core stabilization exercises and positions secondary to left wrist fracture and pain in other areas of spine (cervical) and right UE/hand. During AROM measurements of lumbar, pain right side with flexion/extension/bilateral lateral flexion. Plan: Patient on hold, awaiting physician advising on to continue therapy.

01-29-14: Initial Evaluation. Claimant's low back pain and right hip and leg pain seem to be the worse problem. He notices weakness developing in his leg and has had a couple of episodes when he simply will have the leg give out on him and he will fall. The pain in the low back area and will radiate out into the right hip area and into the back of the right thigh down to about the knee. This bothers him every day and in fact bothers him a big part of everyday, his primary concern.

The claimant's lumbar problem needs further evaluation by MRI for me to actually look at the pictures. He should continue the therapy and medical management. It would be recommended that he try an ESI to his lumbar area and I need to look at his x-rays there.

02-06-14: UR. Reason for denial: Following his accident, the claimant experienced pain in his lower back that radiated to his right hip, thigh and knee, as well as weakness in his leg which caused him to fall. He underwent lumbar x-rays on 8/28/13 which, as read, demonstrated trivial disc space narrowing at L4-5. His MRI on 9/4/13 was interpreted to have shown a minimal annular bulge and a small broad-based disc extrusion at L4-5. His treatments to date have consisted of medications, HEP, and PT, including documented sessions from 9/26/13 to 11/10/13, and from 12/9/13 to 1/20/14. During his most recent evaluation on 1/29/14, the claimant continued to complain of radiating low back pain and leg weakness. He was said to be undergoing PT and taking Tramadol and Neurontin, but these seemed to be helping his neck more than his back. On PE, normal strength was appreciated in the quadriceps, dorsiflexors, and plantarflexors of the legs bilaterally. SLR was negative. Continuation of PT and medication treatment was advised. ESI was also recommended. Guidelines state that ESI may be considered for claimants with objective evidence of radicular pain following failure of conservative care. This claimant is noted to have remained symptomatic despite medications and PT. However, motor and sensory deficits suggestive of L4-5 radiculopathy were not documented in the latest physical examination to clinically warrant an ESI at this level. Also, corroborative objective findings of frank nerve root compromise and/or significant stenosis at L4-5 were not noted in the MRI report provided. Based on these grounds, the medical necessity of this request is not substantiated.

02-17-14: UR. Reason for denial: The latest report submitted for this appeal was dated 11/4/13 where the claimant was noted to have presented for a follow-up evaluation. He complained of pain over the neck and upper back. His medications at this time include cyclobenzaprine, diclofenac, prednisone, and Tramadol. The PE, however, only documented findings for the neck. No physical examination of the lumbar spine was documented in this report. No updated documentation was provided that addressed the aforementioned issues. The foregoing concerns are still unresolved. There is agreement with the previous determination and the medical necessity of this request is still not established at this point. I spoke on 2/12/14 and the case was discussed. Per our discussion, he indicated that the claimant did have radiculopathy in a L4 or L5 distribution. No further findings on physical exam were reported. No other information was provided that would correlate with the provided documentation. Therefore, the determination remains unchanged.

03-15-14: Letter of Explanation. The lack of documentation of physical findings suggestive of radiculopathy in the L4-5 area, radiculopathy is a symptom of pain and does not imply the need for physical findings to be present. In fact, it is my opinion that a large number of patients who have lumbar radiculopathy and in fact may need surgery for a disk herniation do not in fact have any physical findings

such as weakness. Frequently they have positive SLR but does not complain of low back pain and pain in his right hip and down his leg that is classically radicular. HE stated that at times he feels like his leg will give out on him and he might fall. On his evaluation of 1/29/14, the statement was made that “this bothers him everyday and in fact bothers him a big part of everyday”. The statement is also made and documented in line six of the comments that the MRI scan of 9/4/13, showed minimal annular bulge. She neglected to note that the following sentence in that dictation by the radiologist went on to say “superimposed on this, there is a broad based disk extrusion measuring 9 mm in width by 3 mm in AP dimension. This extends superiorly measuring 7 mm.” Furthermore, on the L5-S1 level, “there is a right para central disk extrusion measuring 9 mm in width by 2 mm in AP dimension extending superiorly by 5 mm.” The claimant’s physical examination is in fact unremarkable but he does have back pain and radicular pain and two disk herniation and the best thing for him to try an ESI to see if that will help.

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

Previous adverse determinations of L4-5 ESI are OVERTURNED/DISAGREED with. This is largely based on the letter explanation after the 2 UR's. There is documented radicular pain radiating to right hip, right thigh to the knee, subjective give way weakness of the right knee suggestive of quadriceps deficit, and several Physical Therapy notes with positive supine straight leg raise test with reproduction of thigh pain. This correlates with the body of the Radiologist's reading of the MRI with extensive extruded discs measuring 9 x 3 x 7 mm at L4-5 and 9 x 2 x 5 mm at right L5-S1. This correlates with a clinically suggested persistent Right L4 nerve root irritation despite anti-inflammatory medication and adequate trial of Physical Therapy, and for which an ESI at L4-5 is medically necessary. Therefore, after reviewing the medical records and documentation provided, the request for Lumbar Spine Epidural Steroidal Injection @ L4-5 62311 77003 is approved.

Per ODG:

<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 (due to herniated nucleus pulposus, but not spinal stenosis) 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</p>
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	<p>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. (↵) (↵)</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)**