

Medical Assessments, Inc.

4833 Thistledown Dr.
Fort Worth, TX 76137
P: 817-751-0545
F: 817-632-9684

Notice of Independent Review Decision

January 9, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar ESI @ L5-S1

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

The Reviewer is Board Certified in the area of Anesthesiology with over 6 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:

06/14/2012: MRI Lumbar Spine (missing 2nd page)
07/12/2012: Electromyogram report
03/12/2013: Lumbar Myelogram
03/12/2013: Post-Myelogram CT of the Lumbar Spine
05/14/2013: Evaluation
06/24/2013: Initial Pain Evaluation
07/30/2013: Operative Report
08/08/2013: Functional Capacity Evaluation Report
08/19/2013: Follow up Note
08/26/2013: Designated Doctor Evaluation Report
09/19/2013: Follow up Note
10/07/2013: UR performed

10/23/2013: Follow up Note
11/12/2013: UR performed
11/25/2013: Follow up Note

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his back on xx/xx/xx. The claimant was diagnosed with lumbar radiculopathy.

06/14/2012: MRI Lumbar Spine. Findings: 1. L3/L4: Mild circumferential disk bulge flatten the ventral thecal sac. Mild bilateral ligamentous thickening is seen. Facets are unremarkable. Thecal sac measures about 9 mm in the midline. Mild bilateral craniocaudal foraminal narrowing is seen. 2. L4/L5: Mild circumferential disk bulge flatten the ventral thecal sac. Mild bilateral ligamentous thickening is seen. Facets are unremarkable. Thecal sac measures about 8 mm in the midline. _____ focal disk extrusion is seen just to the left of midline. The extruded disk extends about 8 mm caudally. Moderate left and mild craniocaudal right foraminal narrowing is seen. 3. L5/S1: Mild circumferential disk bulge indents the thecal sac. Ligaments are within normal limits. Facets are unremarkable. Mild right craniocaudal foraminal is seen.

07/12/2012: Electromyogram report. **Impression:** This is a normal EMG of the lower extremities. No evidence of a radiculopathic disease, peripheral neuropathy or myopathy is seen at this time.

03/12/2013: Lumbar Myelogram. Impression: There is evidence from spinal canal narrowing due to the spine stenosis mainly from disk protrusion/extrusion at L3-4 to L5-S1. Diminished nerve root sleeve filling is demonstrated bilaterally these levels. There is also diminished right greater than left nerve root and sleeve filling at L2-3 and a small disk displacement is noted dorsally displacing the dorsal contrast column at L2-3.

03/12/2013: Post-Myelogram CT of the Lumbar Spine. At L3-4, L4-5 and L5-S1, there is a 3 to 4-mm broad-based soft tissue disk protrusion/extrusion, extending two to 3 mm above the interspace at these levels touching and effacing the thecal sac and producing narrowing of the AP spinal canal diameter to 8.5 mm at L3-4, 8.1 mm at L4-5 and 9.9 mm at L5-S1 compatible with significant spinal canal stenosis at L3-4 and L4-5 and borderline spinal canal stenosis at L5-S1. There is bilateral foraminal narrowing at L3-4, and L4-5 and left greater than right canal and foraminal narrowing at L5-S1 due to the slightly eccentric position of the disk protrusion centrally and to the left of midline at L5-S1. At L2-3 There is a 2 mm broad-based soft tissue disk bulge with an additional 2 mm right breast and left foraminal component producing minimal right greater than left foraminal narrowing at L2-3. Minimal facet arthropathy is demonstrated with further posterior foraminal narrowing bilaterally, right greater than left.

05/14/2013: Evaluation. **HPI:** Claimant has what has been noted to be multilevel issues. It is worse at L3-L4 and L4-L5 with 8.5 and 8.1 respectively canal size. At L5-S1 is 9.9 mm. Claimant had already had a normal EMG. Claimant stated that

his discomfort is into the back and goes into his left leg more than right leg. Claimant has numbness in the left thigh anteriorly and then it goes around to the back of his leg and into the calf. **Exam:** SLR on the right side is negative and on the left it causes back and thigh discomfort. **Plan:** Given the MRI findings and noted spinal stenosis, I believe he would be a candidate definitely for injection treatment. I definitely need to see the myelogram CT scan personally to go over with him. I would be hesitant to consider a multilevel fusion but if he had enough stenosis we could consider the aspect of decompression surgery. Claimant does smoke which would be another relative contraindication to the aspect of doing any type of fusion surgery. However, at the present time, I am certain that he is bad off enough as far as neurological to warrant the decompression surgery. We will see how he responds to the injection treatment.

06/24/2013: Initial Pain Evaluation letter. **HPI:** Reported previous treatment included conservative physical therapy and rehabilitative and numerous drug regimens including muscle relaxant, NSAIDs, and weak narcotic analgesia. Current pain graded 10/10 causing him sleep loss, mood irritability, feelings of helplessness, hopelessness, and moderate-to-severe back pain.

Physical Examination: Neuromusculoskeletal: Reveals moderate lumbar interspinous tenderness with a positive straight leg raising sign on the left at 60 degrees. Claimant had moderate lumbar interspinous tenderness pain with flexion, a decreased pinprick sensation in the L5-S1 distribution on the left. Toes were down going. Patrick test of the hips were unremarkable. **Diagnoses:** 1. Chronic back pain syndrome with lumbar disk protrusions following work-related injury. 2. Persist and left lumbar radiculopathy following work-related injury. 3. Myofascial pain syndrome in a patient with moderate reactive depression and insomnia following work-related injury. **Current Medications:** Lisinopril and Clorazepate. **Discussion:** The claimant's prognosis is fair-good, injection therapy and formal lumbar epidural steroid/local anesthetic blockade, may beneficial and hastening the claimant's recovery. Due to the claimant's risk factors as well as reactive depression, I am going to recommend Wellbutrin 150 mg b.i.d. to be begun as well as clonazepam to help him with sleep and neuropathic pain at night. He will receive Neurotin 400mg t.i.d. with Vicodin on a steady-state basis, which will provide daytime analgesia. His intake urinalysis was negative for illicit drug use.

07/30/2013: Operative Report. **Postoperative Diagnosis:** 1. Chronic back pain syndrome with lumbar disk protrusion at L5-S1 and L3-4 following work-related accident. 2. Left lumbar radiculopathy. **Operation Performed:** Not Dictated.

08/08/2013: Functional Capacity Evaluation Report. **FCE Overview & Summary:** Based upon the objective findings from the FCE, the claimant's current overall safe physical demand level (PDL) would be estimated at the Sub-Sedentary PDL, which is still below his current employer's required PDL of Heavy.

08/19/2013: Follow up Note. Claimant is walking with greater ease and sleep has improved. Claimant's left leg pain has nearly completely resolved following a

single lumbar epidural block. Claimant is still complaining of axial back pain radiating into his left buttock and has some left sciatic notch tenderness with a mild positive straight leg raising sign on the left today. Claimant wants to go ahead with a second injection trying to avoid surgical intervention. Continued current drug regimen. Recommending Wellbutrin, Klonopin, Vicodin and gabapentin. Recommend a second lumbar epidural block at the L5-S1 interspace.

09/19/2013: Follow up Note. Claimant is eagerly wanting to go ahead with a second epidural block for his persistent back, buttock and leg pain associated with mild-to-moderate lumbar interspinous tenderness and positive straight leg raising sign with more than 70% pain relief of his back pain and leg pain following a previous ESI. It has now been over 6 weeks since his injection therapy. Unfortunately, the peer doctor, a family practitioner, did a thorough review of the case, resided ODG guidelines elected not to go ahead with a second block even though that is clinically recommended necessary and consistent with the ODG guidelines. I guess he forgot that the paper transfer and request and the scheduling process will take at least 2 to 3 weeks more than 8 weeks of relief since his injection therapy. That being said, the patient is quite pleased with the progress made. He is more functional, more active under our care. His affect is improving as we had to give him samples of mixed norepinephrine, serotonin agent Savalla. We will give him Lexapro, which is not an end drug. This is on the drug formulary for Work Comp and should be approved immediately. Additionally, we will give him Ambien. His sleep is still problematic. The claimant is motivated to get well to do whatever is necessary to avoid surgical intervention. His MRI and laboratory including his EMG have been corroborated. Claimant has multiple levels of disk extrusion. His affect was quite problematic when first seen, but improving with time.

10/07/2013: UR performed. The patient is a male who injured his low back on xx/xx/xx. He is diagnosed with chronic back pain syndrome with lumbar disc protrusion and left lumbar radiculopathy. A request for L5-S1 ESI with fluoroscopy and IV sedation is made. The patient presented with low back pain that radiated to the left greater than right lower extremities. He was noted to have moderate reactive depression and anxiety associated with his pain symptoms. Lumbar MRI dated 5/14/12 demonstrated multilevel disc bulges with bilateral foraminal narrowing. At L5-S1, there was a mild circumferential disc bulge indenting the thecal sac. EMG/NCV dated 10/13/12 was negative. Lumbar CT myelogram dated 3/21/13 showed disc protrusions at L3-4, L4-5 and L5-S1 with narrowing of the spinal canal and bilateral foramina. At L5-S1, there was slightly eccentric position of the disc protrusion centrally and to the left of midline resulting in left greater than right canal and foraminal narrowing. Prior treatments consisted of medications and physical therapy. The patient underwent L5-S1 ESI on 7/30/13. He had 70 percent relief of his back and leg pain for more than eight weeks. He had been more functional and active. On 8/19/13, he was still having axial back pain that radiated to the left buttock. He was noted to have some sciatic notch tenderness and mildly positive straight leg raise on the left. He was recommended Wellbutrin, Klonopin, Vicodin, and gabapentin. As per 9/19/13

follow-up note, he reported persistent back and left leg symptoms. The pain lumbar ESI at L5-S1 was recommended. Although this patient was indicated to have notable pain relief with functional improvement following the initial injection, a recent comprehensive neurologic evaluation of the lumbar spine and lower extremities had not been provided to corroborate ongoing radiculopathy. The patient had been previously documented with motor-sensory deficits consistent with left-sided lumbar radiculopathy, but these were noted prior to the first ESI. The latest records only indicated persistently positive straight leg raise on the left. With the above issue, the medical necessity of this request is undetermined at this time. As such, the request for Outpatient Lumbar ESI @ L5-S1 62311 (PNR FLOURO \$ IV SEDATION 77003) is non-certified.

10/23/2013: Follow up Note. When the claimant was first seen, his pain scores were 10/10. Now with ESI therapy, he is more functional, more active. Claimant is walking with greater ease. He had mild lumbar interspinous tenderness with improved straight leg rising to 70 degrees. As a result, we want to go ahead and recommend a second lumbar block. He did have moderate lumbar interspinous tenderness today with a positive straight leg raising sign at least 70% improved, now 6 weeks after previous injection therapy.

11/12/2013: UR performed. The patient is a male who injured his back on xx/xx/xx. The patient was diagnosed with lumbar radiculopathy. An appeal request was made for L5-S1 ESI under IV sedation. Previous non-certification was given because the patient is only about four weeks out since the last ESI and the degree of pain relief was not objectively documented. There is likewise no evidence of decreased medication use or increase in function resulting from the prior ESI. Lumbar MRI dated 5/14/2012 revealed multilevel disc bulges, worst at L4-5; and disc desiccation was noted at L3-4 and L5-S1. EMG/NCV dated 10/13/2012 was reportedly negative. Lumbar myelogram dated 3/12/2013 showed spinal canal narrowing due to spinal stenosis mainly from disc protrusion/extrusion at L3-4 to L5-S1. The post-myelogram CT showed disc protrusions/extrusions at L3-4, L4-5, L5-S1 extending above the interspace effacing the thecal sac and producing narrowing of the AP spinal canal diameter; and left greater than right canal foraminal narrowing at L5-S1. The patient previously underwent PT. He also had an L5-S1 ESI on 7/30/2013. Updated records include visit notes dated 9/19/13 and 10/23/13. As per 9/19/13 visit note, the patient had more than 70 percent pain relief from the previous ESI. It was mentioned that the "paper transfer and request and the scheduling process" would take at least two to three weeks. Currently, he is presenting with more than eight weeks of pain relief from the previous ESI. The patient was prescribed with Lexapro, Savella and Ambien. As per 10/23/13 visit note, the patient is more functional as a result of the previous ESI. Exam showed positive SLR (which was reported 70 percent improved, now six weeks after the injection). The most recent reports submitted failed to provide and warrant an ESI. Also, it is unclear why the requesting physician is requesting for a repeat ESI, given that it was reported that the patient is still currently having 70 percent relief from the prior ESI done. According to the referenced guidelines, indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. Also, a

clear rationale for requiring the procedure to be done under IV sedation was not provided, as guidelines state that there is no evidence-based literature to make a firm recommendation as to sedation during an ESI. In agreement with the previous determination, the medical necessity of the request has not been established.

11/25/2013: Follow up Note. Claimant was seen for further care regarding his back, buttock, and leg pain complaints. Now, reporting 50 to 60% improvement of his back pain formally 10/10, now 4/10. His sleep is improved. His quality of pain has improved. The patient is more bright today. His affect is improved. His sleep has improved. He has improved range of motion. He is still having shooting pain down that left leg, but not as severe as previously. The guidelines have been met. He should receive a second lumbar ESI as soon as possible.

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

The previous adverse determinations are overturned. After the first ESI, the patient reports 50-60% pain relief, better range of motion, and improved affect and sleep patterns. Patient reports better quality of pain and significant pain relief in his back and legs. Per ODG, additional blocks are indicated if claimant has sustained pain relief of 50-70% for at least 6-8 weeks and that repeat injections should be based on continued objective documented pain relief, decreased need for pain medications and functional response. These criteria have been met; therefore, the request for Lumbar ESI at L5-S1 is certified.

ODG Guidelines:

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 (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.
- (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)**