

Vanguard MedReview, Inc.

4604 Timken Trail
Fort Worth, TX 76137
P 817-751-1632
F 817-632-2619

Notice of Independent Review Decision

June 20, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 L4-L5 Epidural Steroid Injection, outpatient

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

This physician is Board Certified Physical Medicine and Rehabilitation with over 16 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 male who was injured on xx/xx/xx.

05/21/2013: MRI-Spine Lumbar-without contrast. **Impression:** 1 Lumbar Spine moderate-to-severe multilevel chronic degenerative changes most marked at the L1-L2 level. 2. Surgical consultation is recommended. 3. The patient may benefit from epidural steroid pain management injection while the surgical process is completed, if the patient is not a surgical candidate or if surgery is currently not considered an option.

09/09/2013: Progress Note. **History of Present Illness:** Patient was denied ESI as request last visit. Patient states that he has continuous aching, radiating pain in the lower back radiating down to the back of the legs to the knees. Pain is a 6/10. He has had no significant complaints prior to this injury.

Current Medications: Hydrocodone-Acetaminophen 5-325mg, Cyclobenzaprine HCl, Advil **Physical Examination:** Examination confirms clinical evidence of possible segmental instability as well as reactive spondylosis. MRI confirms this, with discrete changes in several of the lumbar disks, without degenerative changes to account for these symptoms. **Assessment:** 1. Lumbar –herniated disc; intervertebral disc disorders, displacement lumbar intervertebral disc without myelopathy-722.10 (primary) 2. Disorders of sacrum-724.6 **Treatment:** 1. Lumbar herniated disc; intervertebral disc disorders, displacement lumbar intervertebral disc without myelopathy. Based upon his previous lack of symptoms prior to his injury, a significant mechanism of his injury, prompt onset of symptoms and evidence of local trauma following his injury as well as examination and MRI findings, I again request epidural steroid injections. If these fail to relieve symptoms, the patient will be a candidate for provocative discography to define his pain generator in the lumbar area.

10/28/2013: Initial Evaluation. **History of Present Illness:** The patient states that since the time of injury he's had pain radiating into his lower extremities. Pain is worse when he tries to bend over and he does continue to work despite having pain in his lower back and legs. He has been doing physical therapy, and states that this has not helped treat his pain. He describes his pain as aching, throbbing, sharp, exhausting, and miserable. In quality his pain is intermittent. He states that at this time his pain is a 7/10. Pain is worse with sitting, squatting, kneeling, standing, bending over, driving, and twisting. His pain is relieved with medications and rest. He does state that his pain does interfere with his ADL's, functional mobility, as well as ability to sleep. **Examination:** General appearance: NAD, A and Ox3, pleasant, uncomfortable due to pain. Back: Increased lumbar pain greater with flexion, no lumbar paraspinal tenderness, he does have guarding with ROM of his lumbar spine secondary to pain, normal gait. Extremities: Motor strength is 5/5 in the bilateral lower extremities, sensation is intact bilaterally, negative straight leg raise bilaterally. **Assessment:** 1. Chronic pain syndrome-338.4 (primary) 2. Lumbosacral neuritis NOS- 724.4 3. Opioid type dependence, continuous- 304.01 **Treatment:** Continue Advil tablet, 200 mg, 1 tab(s), orally, PRN. Continue Norco tablet, 325 mg-5 mg, 1 tab(s), orally, PRN. Will schedule for a series of three L4-5 lumbar epidural steroid injections. Will see the patient back 1 week after his first lumbar epidural steroid injection to see how he is doing.

11/20/2013: Follow Up Visit. **Examination:** General appearance: NAD, A and Ox3, pleasant, uncomfortable due to pain. Neurologic exam: 5/5 motor strength bilaterally throughout except 4/5 strength in LLE, normal sensation, normal tone, gait normal. Back: Increased lumbar pain greater with flexion, no lumbar paraspinal tenderness, he does have guarding with ROM of his lumbar spine secondary to pain, normal gait. Extremities: Motor strength is 5/5 in the bilateral lower extremities, sensation is intact bilaterally, negative straight leg raise bilaterally. **Assessments:** Chronic pain syndrome-338.4 (primary), Lumbosacral neuritis NOS-724.4, Opioid type dependence, continuous-304.01 **Treatment:** Continue Advil tablet, 200 mg, 1 tab(s), orally, PRN. Continue Norco tablet, 325 mg-5mg, 1 tab(s), orally, PRN, 30 days, 30, Refills 0. Will see the patient back 1 week after his first lumbar epidural steroid injection to see how he is doing, but will

have to get WC to approve injections first. In interim, will have to prescribe some medication to control his pain until he can get injections performed.

12/04/2013: Operative Report. **Postoperative Diagnosis:** Lumbosacral neuritis. **Operation Performed:** Interlaminar L4-5 epidural steroid injection under fluoroscopic guidance.

12/17/2013: Office Visit. **History of Present Illness:** The patient returns to the office for a post procedure check up. He says he has not needed to take any medications by mouth since the epidural steroid injection a week ago. He is thrilled by this. He says where his pain used to be about a 6/10 it is now a 1-2/10. He reports at least a 75% improvement of his pain. Pt reports he takes an Advil on days when he doesn't take hydrocodone and this has been only before the procedure. He says he will call for another appointment when his medication runs low. Pt appears compliant with his medication regimen without side effects. There is no evidence of abuse or diversion. **Assessment:** Chronic pain syndrome-338.4 (primary), Lumbosacral neuritis NOS-724.4, Opioid type dependence, continuous-304.01 **Treatment:** Continue Advil tablet, 200 mg, 1 tab(s), orally, PRN Continue Norco tablet, 325 mg-5mg, 1 tab(s), orally, PRN, 30 days, 30, Refills 0. Continue Norco for breakthrough pain. He has enough at home for another month as he has not been taking since the injection.

03/19/2014: Office Visit. **Reason for appointment:** 1. NP, alcohol present-discuss alcohol policy, only give 2 wks, if this happens again, is grounds for dismissal. Follow up visit. 2. Lower back pain 3 SOAP-R score 9 4. AMD 4, 0/5 suicide risk, 10/28/13, repeat 6 months. **Examination:** General appearance: NAD, A and Ox3, pleasant, uncomfortable due to pain. Neurologic exam: 5/5 motor strength bilaterally throughout except 4/5 strength in LLE, normal sensation, normal tone, gait normal. Back: Increased lumbar pain greater with flexion, no lumbar paraspinal tenderness, he does have guarding with ROM of his lumbar spine secondary to pain, normal gait. Extremities: Motor strength is 5/5 in the bilateral lower extremities, sensation is intact bilaterally, negative straight leg raise bilaterally. **Assessment:** 1. Chronic Pain Syndrome-338.4 2. Lumbosacral neuritis NOS-724.4 3. Opioid type dependence, continuous-304.01 **Treatment:** Continue Advil tablet, 200 mg, 1 tab(s), orally, PRN, continue Norco tablet, 325 mg-5 mg, 1 tab(s), orally, PRN, 30 days 30, Refills 0. Rx Norco, no refills (2 wks given). Will attempt to get another epidural approved through insurance at L4-5, was apparently denied in January, will have to appeal. Pt had alcohol in his urine, policy discussed with pt, he is on very small amount of opioids, but it is still office policy not to have alcohol in the system while on controlled substances, pt voiced understanding and will comply. Today's urine will likely have some; pt states will not drink further. **Follow Up:** 2 weeks

04/02/2014: Office Visit: **History of Present Illness:** The patient returns to the office for follow up. He hasn't really been taking anything for pain other than Advil etc. He says it helps some, but his pain is starting to come back. He says pain level is about 5-6/10 most of the time. He says the previous injection gave him >75% relief of his pain where he did not have to really take anything for pain until

the last few weeks. He would like to have the injection again because this controlled his pain so much better without having to take medication. He is starting to have his pain in his back flare up, especially when he is working. He is working as an electrician, which requires him to bend over frequently, which exacerbates his pain. Pt has not been having pain back into his legs yet, so this is definitely improved since his injection. Pt appears compliant with his medication regimen without side effects. There is no evidence of abuse or diversion.

Assessment: Chronic pain syndrome-338.4 (primary), Lumbosacral neuritis NOS-724.4, Opioid type dependence, continuous-304.01 **Treatment:** Continue Advil tablet, 200 mg, 1 tab(s), orally, PRN Continue Norco tablet, 325 mg-5mg, 1 tab(s), orally, PRN, 30 days, 30, Refills 0. Rx Norco, no refills. Will attempt to get another epidural approved through insurance at L4-5.

04/09/2014: UR. Rational for Denial: Although the claimant reportedly had positive improvement from prior injection, the recent physical examination findings have not noted true evidence of radiculopathy. The guidelines would not support epidural steroid injections without clinical documentation of radiculopathy with correlation of imaging and/or electrodiagnostic testing.

05/02/2014: UR. Rational for Denial: The claimant is a male with a date of injury of xx/xx/xx. The compensable body part is the lumbar spine. The request is for reconsideration of lumbar interlaminar epidural steroid injection at L4-L5. I attempted to reach the requesting physician. She was not available. I did not receive a call back. Medical records do not indicate evidence of acute radicular symptoms. There is no decrease in medication documented with prior epidural steroid injections and at this time the request is recommended for non-certification as being not medically necessary reasonable or necessary.

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

The previous adverse determinations are upheld. Denial of repeat L4-5 ESI is upheld/ agreed upon since there is lack of documentation of objective findings of radiculopathy correlating with diffuse/multilevel degenerative changes on MRI. And there is no documentation of more recent conservative measures, particularly physical therapy and/ or compliance with a Home Exercise program. Therefore, 1 L4-L5 Epidural Steroid Injection, outpatient is not medically necessary at this time and should be denied.

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 (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)**