IRO NOTICE OF DECISION – WC

Claims Eval

Notice of Independent Review Decision

IRO NOTICE OF DECISION – WC

October 20, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L5/S1 Selective Nerve Root Injection w/ IV Sedation (64483
77003, 99144)

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

American Board of Orthopaedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

Xx/xx/xx Hospital-Emergency Room, the claimant complains of right lower extremity pain. Impression: Lumbar radiculopathy, lumbar strain, sciatica, possible herniated disk. Plan: The claimant was prescribed Vicodin, Ibuprofen, Flexeril.

Xx/xx/xx Lab work performed.

Xx/xx/xx CT of the lumbar spine without contrast performed showed degenerative changes. No acute bony abnormality.

1-15-14 MRI of the lumbar spine without contrast showed segmentation, presumed hypoplastic 12th ribs. Previously described fracture of the superior endplate of L4 with Schmorl's node type protrusion of the nucleus pulposus into the superior portion of fracture. No significant canal stenosis. No focal impingement detected.

1-9-14 Unknown Provider, the claimant complains of low back pain radiates down right leg. Diagnosis: Lumbar back pain-radiculopathy. Plan: The claimant was prescribed Lortab. Continue Ibuprofen. Continue home physical therapy. (Other illegible hand written notes).

1-9-14 Physical Therapy -referral.

Follow-up visit with Unknown Provider on 1-13-14 notes the claimant was continued with medications. The evaluator order MRI of the lumbar spine. Start physical therapy.

Physical Therapy on 1-15-14.

Follow-up visit with Unknown Provider on 1-16-14, 1-21-14 notes the claimant was continued with medications.

1-22-14 Request for preauthorization and concurrent review.

1-24-14 PAC., the claimant complains of low back pain especially on the right side. Assessment: Fracture of superior end plate of L4 with disc protrusion. Plan: The claimant was prescribed physical therapy, Hydrocodone. Refill Ibuprofen.

1-30-14 Unknown Provider, the claimant complains of low back pain. The claimant states pain is controlled with medications. He is seen specialist and will be put in a back brace. Diagnosis: Superior endplate, L4 fracture. Plan: (illegible hand written notes).

Follow-up visit with Unknown Provider on 2-20-14 notes the claimant was continued with medications. Follow-up.

3-12-14 Physical Therapy Evaluation.

Physical Therapy on 3-19-14.

Follow-up visit with Unknown Provider on 3-20-14 notes the claimant was continued with medications and start physical therapy. Follow-up.

3-20-14 Request for preauthorization and concurrent review.

Follow-up visit with Unknown Provider on 4-17-14 notes the claimant was continued with medications and physical therapy. Follow-up.

5-19-14 Request for preauthorization and concurrent review.

5-27-14, the claimant complains of low back pain. He states he is doing better. The claimant will be released from his care at this time. The evaluator will have do an impairment rating on him.

6-3-14 Unknown Provider, the claimant complains of low back pain. The claimant states he was released from ortho. Diagnosis: Low back pain, fracture superior endplate, L4 disc protrusion. Plan: (illegible hand written notes).

6-9-14 Unknown Provider, the claimant complains of low back pain. The claimant states back pain is more and medications is not helping. Diagnosis: Low back pain, fracture superior endplate, L4 disc protrusion. Plan: Continue medications. Discontinue Tramadol. (Other illegible hand written notes).

6-23-14, performed an Impairment Rating. He certified the claimant had reached MMI on 5-27-14 and awarded the claimant 5% whole person impairment.

6-23-14 Functional Capacity Evaluation shows the claimant is functioning at a Sedentary-Light PDL.

6-25-14 Unknown Provider, the claimant complains of low back pain. The claimant states the pain is worse at night. Diagnosis: Low back pain, fracture superior endplate, L4 disc protrusion. Plan: The claimant was prescribed Mobic, Flexeril, and Norco. Discontinue Ibuprofen. (Other illegible hand written notes).

7-14-14 Unknown Provider, the claimant complains of low back pain. The claimant states he is unable to schedule for ESI due to outstanding balance. Diagnosis: Low back pain, fracture superior endplate, L4 disc protrusion. Plan: The claimant referred to ortho. Continue Flexeril, Ibuprofen, and Norco. Discontinue Mobic. (Other illegible hand written notes).

8-19-14 Pain diagram.

8-20-14, the claimant complains of significant back and posterior buttock pain. The claimant is a male who is referred for evaluation of significant lower back complaints radicular pain in the buttock area. He has had significant back pain and radicular pain more in the buttock areas. Pain was quite severe where he has difficulty standing upright. He had approximately 8 weeks of physical therapy without any significant improvement. AP and lateral views of the lumbar spine show retrolisthesis and collapse of L3-4 degeneration at L5-S1. MRI of the lumbar spine show evidence of foraminal compromise at the L5-S1. With degeneration of the superior articulating facet with some narrowing of the recess at L5-S1. Disc degeneration and protrusion at L3-4. Assessment: Lumbosacral neuritis or radiculitis-unspecified, low back pain, lumbar spinal stenosis. Plan: The claimant was prescribed Norco, Gabapentin, and Ibuprofen. His recommendation is for both diagnostic and therapeutic block on the right side at L5-S1. His response to that will help determine what the best options for further treatment. If his symptoms resolve then the evaluator will continue to observe him to a core conditioning program. If he continues to have fairly intractable radiculopathy and inability to function but the pain is focal to the S1 segment he may benefit from an isolated foraminotomy.

8-20-14 X-ray of the lumbar spine performed showed mild grade 1 retrolisthesis of L3 on L4 which is stable between the flexion and extension view. Narrowing of l3-L4 and L5-S1 disc spaces. Facet joint degenerative change at L4-L5 and L5-S1 levels.

8-21-14 Fax coversheet.

8-28-14, performed a Medical Review. It was her opinion based on the clinical information submitted for this review and using the evidence based, peer-reviewed guidelines, this request for right L5-S1 selective nerve root injection with IV sedation is non-certified. He noted the clinical information submitted for review indicates that the patient complains of low back pain with radiation into the bilateral buttocks. It was also noted that he has failed initially recommended conservative treatment. However, there was no evidence of neural foramina, narrowing or nerve root irritation on his CT scan or MRI performed in 01/2014. In addition, his most recent physical examination performed on 08/20/2014 was noted to reveal no significant findings of radiculopathy such as decreased motor strength or sensation in specific myotomal or dermatomal distributions. He was noted to have a positive straight leg raise on the right side; however, it was also noted that his straight leg raises were normal bilaterally. In the absence of documentation showing significant physical examination findings suggestive of radiculopathy without corroboration by imaging studies, the requested diagnostic epidural steroid injection is not supported. In addition, the Official Disability Guidelines state that routine use of sedation is not recommended for epidural steroid injections except for patients with severe anxiety. The documentation failed to provide a rationale for the requested IV sedation and there was no documentation indicating that the patient had a history of anxiety. Therefore, the request for IV sedation would also not be supported. For the reasons

noted above, the request for OP Right L5/51 Selective Nerve Root Injection w/IV sedation 64483 77003 99144 is non-certified.

9-26-14, performed a Medical Review. It was his opinion based on the clinical information submitted for this review and using the evidence based, peer-reviewed guidelines, this request for appeal right L5-S1 selective nerve root injection with IV sedation is non-certified. He noted that there is no documentation of nerve root compromise noted on the patients imaging studies. There was no documentation of physical exam findings suggestive of radiculopathy without corroboration by imaging studies.

9-30-14 Request for a Review by an Independent Review Organization.

10-1-14 Notice to Claims Eval of Case Assignment.

10-1-14 This letter is to notify you that the claimant, the claimant's representative, or the claimant's provider requested independent review by an independent review organization (IRO). The Department certifies IROs. The IRO is independent of the payor (the claimant's health plan or insurance company), the payer's utilization review agent (URA), and health care providers.

10-1-14 Notice to Utilization Review Agent of Assignment to Independent Review Organization.

10-1-14 Fax coversheet; IRO Notice of Assignment (IRO).

10-1-14 Independent Review Details.

10-1-14 Fax coversheet; IRO Notice of Assignment (ADP).

10-2-14 Fax coversheet; to: Claims Eval.

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

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. MRI dated 1-15-14 noted no significant canal stenosis. No focal impingement detected. There is an absence in documentation noting objective findings supporting nerve root impingement or compromise at the L5-S1 level. Physical exams are also nonspecific for radiculopathy. Therefore, the requested procedure for right L5/S1

Selective Nerve Root Injection w/ IV Sedation (64483 77003, 99144) is not reasonable or medically necessary.

ODG 2014 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)**