

CASEREVIEW

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Notice of Independent Review Decision

July 23, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar ESI

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

This physician is a Board Certified Anesthesiologist with over 7 years of experience including Pain Management.

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. He felt "tightness" in his lower back after helping to lift a 250 pound x. A few minutes later he was on the floor and felt a "pop" with severe stabbing pain in his lower back. He sought treatment at the ER on 12/22/14 where a CT scan was completed and he was given an injection for the pain. He went to the ER again on 12/31/14 and was placed on more stringent work restriction, physical therapy was ordered and he was given a different muscle relaxer.

On December 22, 2014, CT Lumbar Spine, Impression: Degenerative disc and facet disease. No evidence of compression, subluxation.

On January 6, 2015, the claimant presented with constant pain in his lower back with radiation into the left hip and posterior left leg, as well as to the right upper back, neck and posterior shoulder. Pain was rated 5-8/10. On examination there was moderate spasms on the right side of the thoracic region, extending into the lumbar region. There was tenderness to palpation of the lower lumbar spine. Lumbar ROM was limited in all directions with pain-limited effort. Straight leg raises were positive on the left (hip pain) at 60 degrees and negative on the right. FABER was positive bilaterally, much worse on the left. DTR's 2+ and symmetric. Poor pinwheel sensation report in all upper and lower extremity dermatomes. No myotomal strength defects noted. Gait was guarded but otherwise normal and without limp. Plan: Physical therapy and

continued use of the prescribed medication (Mobic, Gabapentni, Tramadol, Hydrocodone, Baclofen).

On January 27, 2015, the claimant presented with no improvement. Therefore an MRI was requested.

On February 2, 2015, MRI Lumbar Spine, Impression: 1. At L4-5 there is a broad based posterior disc protrusion with facet arthrosis. This results in moderate bilateral foraminal and lateral recess narrowing with moderate abutment of both exiting and descending nerve roots. 2. Degenerative changes at L5-S1 result in moderate bilateral foraminal narrowing with mild abutment of the exiting nerve roots. 3. There is mild bilateral foraminal and lateral recess narrowing at L3-4 without significant nerve root impingement.

On February 4, 2015, the claimant presented after completing 6 sessions of PT with minimal improvement. He still reported constant stabbing pain in his lower back, radiating to the upper back, both hips and legs, and around his trunk into his right groin and down the front of his right leg. He reported that the pain level waxes and wanes, ranging from 5 at best to 10 out of 10 with activity. He reported associated numbness and paresthesias in his right leg from the knee down and both feet. He also continued to complain that when he stands straight up he feels like he needs to have a bowel movement and that the sensation is getting worse. Plan: Refer for surgical evaluation.

On March 6, 2015, the claimant presented for surgical evaluation. On examination DTRs were symmetrical and there were no sensory defects. Plan: Recommend pain clinic eval for possible LESI. stated he doubted surgery for lumbar disease would clinically benefit him.

On April 21, 2015, the claimant presented who reported he had completed some physical therapy with TENS unit and heat that was helpful. Currently taking Tramadol, Baclofen, Gabapentin and Meloxicam. He reported the pain was better when sitting and laying and worse when standing. He was working. On examination there were no gross sensory or motor deficits. Plan: Lumbar ESI

On April 30, 2015, UR. Rationale for Denial: ODG Low Back Chapter criteria for ESI states radiculopathy must be documented on exam and corroborated with imaging studies and/or EMG, and initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). The exam provided states he has had PT with TEMS unit and heat and it was helpful. He continues on medications and is currently working. The most recent exam states only "no gross sensory or motor deficits." Based on the documentation provided the request does not meet the treatment guidelines as presented.

On June 1, 2015, UR. Rationale for Denial: Based on the clinical information provided, the appeal request for one lumbar epidural steroid injection is not recommended as medically necessary. The initial request was non-certified noting that the exam provided states he has had PT with transcutaneous electrical nerve stimulation (TENS) unit and heat and it was helpful. He continues on medications and is currently working. The most recent exam states only "no gross sensory or motor deficits". There is insufficient information to support a change in determination, and the previous non-certification is upheld. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's physical examination fails to establish the presence of active radiculopathy. The request is nonspecific and does not indicate the level/laterality to be injection.

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

The previous adverse determinations are upheld. The claimant has had PT with transcutaneous electrical nerve stimulation (TENS) unit and heat with relief. He continues on medications and is currently working. Most recent physical examination states only "no gross sensory or motor deficits". Per ODG, there must be documentation of radiculopathy on physical examination corroborated by imaging studies and/or

electrodiagnostic results. The patient's physical examination fails to establish the presence of active radiculopathy. Therefore, this request for Lumbar ESI 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 (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, muscle relaxants & neuropathic drugs).
- (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)**