

MEDRx

3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069
Ph 972-825-7231 Fax 972-274-9022

Notice of Independent Review Decision

DATE OF REVIEW: 1/20/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a left SI transforaminal injection.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a left SI transforaminal injection.

A copy of the ODG was not provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The Injured Worker sustained a work related injury to the lower back on xx/xx/xx while employed. According to the records, he slipped and fell while lifting. He was seen on xx/xx/xx with back pain radiating to the left and right calf. Lumbar spine examination revealed muscle spasm and moderate pain with movement. He was treated with an injection of ketorolac and was advised to apply ice packs. A prescription was written for tramadol,

Naprosyn and Zanaflex. On 08/22/14, the back pain was improving with no radiation. Lumbar spine exam revealed posterior tenderness with paravertebral muscle spasms, normal flexion and extension and normal lateral flexion. The diagnosis was lumbar sprain or strain 847.2. Physical therapy referral was made. On subsequent outpatient follow up visits, the lower back pain persisted despite treatment with physical therapy and medications. Symptoms were aggravated by bending, relieved by pain medications and drugs. On 10/17/14, the symptoms were aggravated by bending, relieved by physical therapy. On 10/25/14, noted that the worker continued to have pain with bending and lifting but has some improvement. Examination revealed tenderness over the lower lumbar area. Deep tendon reflexes were normal in the lower extremities, with negative straight leg raising bilaterally. On 10/11/14, the examination was positive for posterior tenderness with paravertebral muscle spasm and left lumbosacral tenderness. Lumbar motion was normal. The plan was to refer the worker to an orthopedic surgeon for evaluation and treatment.

The worker was evaluated on 12/12/2014. Pain was primarily on the left lower back with intermittent radiation into the left hamstrings to the knee, with no tingling or numbness in the leg, no saddle anesthesia or bladder dysfunction. He was working full-time. Lumbar examination revealed no paravertebral muscle tenderness, no evidence of spasm or trigger point. Lumbar range of motion was normal. Spinous processes were non-tender. Straight leg raising was normal. Lower extremity strength and reflexes were normal. Light touch was normal. X-rays of the lumbar spine were reported to show minor degenerative changes at L5-S1, with otherwise negative findings. MRI from October 23, 2014 was interpreted to show L5-S1 degenerative disc changes with a small central disc protrusion and no severe neurologic impingement. The assessment was L5-S1 central disc herniation, back pain with left hamstring intermittent pain, normal neurologic exam, failure of four weeks of [treatment with] physical therapy and Relafen. "He may benefit from a left S1 epidural injection". The diagnosis was 722.10 HNP displacement of lumbar vertebral disc without myelopathy. submitted a request for transforaminal epidural steroid injection at the S1 level on the left. The request was non-certified. The decision was appealed. On peer review, the non-certification was upheld.

DIAGNOSTIC STUDIES

2014/10/23: MRI of The Lumbar Spine Without Contrast,

- Findings were reported to be normal at the L1-L5 intervertebral disc levels.
- There is a five millimeter broad-based protrusion arising from the posterior central and paracentral portion of the [L5-S1] inter-vertebral disc causing mild impression on the anterior surface of the thecal sac without spinal stenosis. The neural foramina are intact.

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

In the records submitted for this review, the findings on the imaging studies and the physical examinations do not support a diagnosis of radiculopathy.

According to the ODG –TWC ODG Treatment Integrated Treatment/Disability Duration Guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 01/14/15), regarding Criteria for the use of Epidural steroid injections:

(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.

According to the ODG –TWC ODG Treatment Integrated Treatment/Disability Duration Guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 01/14/15), as cited in the reference Andersson GBJ, Cocchiarella L, American Medical Association. Guides to the Evaluation of Permanent Impairment, Fifth Edition. Hardcover - Dec 15, 2000.

Radiculopathy (page 382-383)

“is defined as significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots. The diagnosis requires a dermatomal distribution of pain, numbness, and/or paresthesias in a dermatomal distribution. A root tension sign is usually positive. The diagnosis of herniated disk must be substantiated by an appropriate finding on an imaging study. The presence of findings on an imaging study in and of itself does not make the diagnosis of radiculopathy. There must also be clinical evidence as described above.”...

The most important clinical components required to support the diagnosis of a compressive Radiculopathy include:

- Pain, numbness, and/or paresthesias in a dermatomal distribution
- An imaging study documenting correlating concordant nerve root pathology
- Associated clinical findings such as loss of relevant reflexes, muscle weakness and/or atrophy of appropriate muscle groups, loss of sensation in the corresponding dermatome(s)

Electrodiagnostic studies are helpful in supporting the diagnosis of a compressive radiculopathy but are not required, and do not substitute for imaging studies.

Reference Material: Epidural steroid injections (ESIs), therapeutic

Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. Not recommended for spinal stenosis or for nonspecific low back pain.

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.)

As cited in the ODG Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 01/14/15): Andersson GBJ, Cocchiarella L, American Medical Association. Guides to the Evaluation of Permanent Impairment, Fifth Edition. Hardcover - Dec 15, 2000.

The request does not meet the criteria set forth in the ODG; therefore, the request is not medically necessary.

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)