

Health Decisions, Inc.

6601 CR 1022

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May 28, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Monitored Anesthesia for ESI

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

An American Board Certified Anesthesiologist with 6 years' 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

Medical records reflect the patient is a female that sustained an injury when she bent over to unlock a bar on. This did not involve any heavy lifting. It was merely a bending over maneuver. Her initial exam at assessment revealed a Lumbar Strain and patient was referred for MRI and treated for pain.

09/12/13: EMG: Interpretation: EMG of the the right lower extremity and lumbosacral paraspinals is within normal limits. A repeat EMG may be considered in 6-12 months if clinically worsening or indicated. There is no neurophysiologic evidence of peripheral neuropathy/ myopathy. No evidence of L3-S1 radiculopathy/ peroneal neuropathy/posterior tibial neuropathy/sciatic neuropathy/ lumbosacral plexopathy on the right side. Clinically patient may have sacroiliitis bilaterally. Conservative treatment, including local steroid injection of SI joint may be considered.

11/23/13: X-Ray of the Lumbar Spine: Impression: Hyperlordosis and levorotatory lumbar scoliosis of approximately 20 degrees. Clinical correlation for abnormal biomechanics. No evidence of segmental instability. Marked degenerative disc, spondylosis at L2-L3, and moderate disc space narrowing L5-S1. Mild

degenerative hypertrophic changes of facet joints, most pronounced at L4-L5 and L5-S1. Mild degenerative changes of the sacroiliac joints.

11/23/13: MRI of the Lumbar Spine: Impression: Mild disc degeneration with a prominent right paramedian 5 mm herniation of the L5-S1 disc that compresses the S1 nerve root. Mild degeneration of the L4-L5 disc with a broad based left paramedian 3-4 mm protrusion and left posterolateral annular bulge, which compresses the traversing L5 nerve root and compromising the exiting L4 nerve root. Moderately advanced disc degeneration, spondylosis with asymmetrical posterolateral annular bulge of L2-L3, creating foraminal stenosis, right greater than left and right lateral recess stenosis. Clinical correlation for associated right sided L2 and/or L# radicular involvement. Hyperlordosis and levorotatory scoliosis of lumbar spine, with incision, mild atrophy of erector spinate. See concomitant radiographic report. Clinical correlation advised for myospasm, articular dysfunction and/or other abnormal spinal biomechanics. Mild degenerative hypertrophic changes of facet joints.

01/16/14: Office visit: Recommendations: This patient has suffered for greater than 2 weeks from radicular symptoms without a specifically identifiable spinal nerve level etiology. There are documented findings on examination supporting a radicular pathology. MRI findings are consistent with multilevel pathology, either central, lateral recess or foraminal stenosis, likely to cause radicular pathology, however exact source for pain is ambiguous. Physical therapy/ NSAID's/ muscle relaxants have failed to control symptoms. There are no positive Waddell's signs or evidence of psychosocial pathology that would preclude performance of the recommended transforaminal injection procedure. Fluoroscopic guidance is indicated to assure proper injection placement and to optimize diagnostic outcome.

02/11/14: Procedure: Lumbar radiculitis. Postoperative Diagnosis: Degenerative L5-S1 disc with primary symptomatic right S1 radicular pain. Procedure: Fluoroscopically guided needle localization of the right L5 and S1 spinal nerves with transforaminal epidurograms and epidural injection of local anesthetic and steroid. Patient was transferred to PACU in good condition.

02/26/14: Office visit: Currently the patient has 75% relief after lumbar transforaminal injection. Exam: Patients gait was tandem with normal station. Straight leg raise testing while seated was negative bilaterally. Waddell's signs not present. Lumbar alignment shows: S-type scoliosis with upper left and lower right convexity mild. Moderate muscles spasm noted: right mid-lumbar paraspinal musculature. Point of Maximum Tenderness: right mid lumbar paravertebral. Range of motion is normal for age in flexion, extension, rotation and lateral bending despite pain with flexion. PT / Rehabilitation: Lumbar Stabilization and ROM exercises 2 times a week for 3 weeks. Activity modifications discussed to accommodate for their spinal pathology.

05/14/14: Office visit: Symptoms are worse since last evaluation. Patient complains of right lower lumbar pain. Current VAS 2-3/10. The patient also

complains of right lower extremity pain is noted in the hip posteriorly and thigh posteriorly. Lumbar alignment shows: S-type scoliosis with upper left and lower right convexity mild. Moderate muscles spasm noted: right mid-lumbar paraspinal musculature. Point of Maximum Tenderness: right lower lumbar paravertebral. Range of motion is normal for age in flexion, extension, rotation and lateral bending despite pain with flexion. Patient was given a Medrol Dosepack. Patient to continue home exercise program. Body mechanics and core strengthening were discussed with patient.

05/28/14: Office visit: Patient complains of right upper lumbar pain and right lower extremity pain in the hip laterally and thigh anteriorly. Current VAS 4-5/10. The symptoms are somewhat better since last evaluation. Medrol dose pack provided 50% relief during that week. Patients gait is antalgic and slow & guarded. Lower extremities showed bilateral 5/5 strength with normal tone L1-S1 except 5-/5 right hip flexors (psoas/iliacus L2-4). Straight leg raise testing while seated was negative bilaterally. Waddell's signs not present. Lumbar alignment shows: S-type scoliosis with upper left and lower right convexity mild. Point of maximum Tenderness: upper right lumbar paravertebral. ROM limited in extension by pain, right lateral bending by pain and arising from a forward flexed position by pain. Recommendation: transforaminal injection procedure Right L2 and L3. Fluoroscopic guidance is indicated to assure proper injection placement and to optimize diagnostic outcome.

03/20/15: Review of Medical Records: Based on the medical record review including the mechanism of injury, image studies, as well as the electrodiagnostic study the patient sustained a lumbar strain/sprain. Her multiple physical examinations consistently failed to document objective signs of lumbar radiculopathy, decreased to absent relevant reflex, as well as with or without 2cm or more atrophy of the ipsilateral extremity. Also imaging studies revealed that the SI joint had degenerative disc disease bilaterally. Thus, it appears the patient was having intermittent right SI joint pain because SI joint pain sometimes can be referred to the knee. The imaging studies were inconsistent in that the first MRI of August 13, 2013 noted multilevel lumbar degenerative disk disease with a 1mm L5-S1 disc bulge. The second MRI on November 23, 2013, reportedly revealed besides multilevel lumbar degenerative disc disease, manifested by multilevel facet hypertrophy, multilevel disc protrusions/osteophyte complexes producing multilevel nerve root compressions not only on the left but also on the right per report. The point here is that in order for a disc herniation as seen on imaging studies to be clinically relevant, there must be consistent documentation of positive objective clinical findings corroborating the imaging finding. Otherwise the finding is not clinically relevant. In this case, there was never any documentation of objective signs of radiculopathy such as severely decreased reflexes or absent reflexes and / or 2 cm or more atrophy of the ipsilateral extremity. Hence, further treatment as it relates to the index injury is not medically necessary or reasonable.

04/22/15: Office visit: The patient reports right lower lumbar pain. Current VAS 5/10. Their symptoms are gradually worsening since last evaluation. The patient reports insomnia associated with pain. Current medications: Celebrex 200 mg, 1

capsule QD. Tramadol 50mg 1 tablet QD PRN. Zanaflex 2mg, 1 capsule QD PRN, Cymbalta 60mg, 1 capsule QD, Lyrica 50mg, 1 capsule BID, Norco 10-325mg, 1 tablet QD PRN. Patient's gait is antalgic and slow & guarded. Straight leg raise testing while seated was negative bilaterally. Waddell's signs not present. Motor testing showed well developed and symmetrical musculature in the bilateral lower extremities. No evidence of any weakness L1-S1. No atrophy or fasciculations were noted. Tone normal. Lumbar alignment shows: S-type scoliosis with upper left and lower right convexity mild. Point of Maximum Tenderness: upper right lumbar paravertebral. ROM limited in extension by pain, right lateral bending by pain and arising from forward flexed position by pain. Recommendations: Due to delicate nature of this procedure coupled with work in a sensitized painful area around vital neurovascular structures in a patient with anxiety, anesthesia services are indicated for patient comfort and safety. Fluoroscopic guidance is indicated to assure proper placement of the steroid and optimize outcome. This treatment is medically necessary to allow this patient to progress with active ongoing rehabilitation efforts. Patient to continue home exercise program.

05/04/15: UR: I would agree with the epidural injection under fluoroscopy but without monitored anesthesia. The MRI shows nerve root impingement. Because of the scoliosis, the surgeon does not want to operate on her back. He said they did not get good cephalad flow on the injectate to the L4/5 level, which is why they want to go up one level with the next injection, as well as the L5/S1 level. He said her leg symptoms are much better from the first injection, but are still present. He said that when she forward flexes, she has pain down her right leg, posteriorly. He believes that the severe foraminal stenosis along with the scoliosis is creating a complex pattern in her back. I would agree with the injection at two levels. The fluoroscopy is needed to monitor the location and flow of the injectate. There is no indication of severe anxiety or other reason to use monitored anesthesia. Therefore, Lumbar ESI with Fluoroscopy at Rt. L4, L5 and S1 is medically necessary; however, Monitored Anesthesia is not medically necessary.

05/06/15: UR: Medical records reflect the claimant is a female who sustained a work injury. The claimant has exam findings that support radicular pathology and MRI findings that are consistent with stenosis. The evaluator recommended Transforaminal Epidural Steroid Injection, fluoroscopic guidance. UR approved an Epidural Steroid Injection at right L4-L5 and S1 with fluoroscopy but monitored anesthesia was not approved. The appeal for Monitored Anesthesia for an Epidural Steroid is not medically necessary. ODG notes that Epidural Steroid Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. However, there is no indication that monitored anesthesia is necessary. As such based on the current guidelines, medical necessity cannot be supported.

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 exams findings that support radicular pathology and MRI findings that are consistent with stenosis. The evaluator recommended Transforaminal Epidural Steroid Injection, fluoroscopic guidance. While the procedure is approved, there is no indication or extenuating circumstance to justify the need for monitored anesthesia for the ESI. Therefore, the medical necessity of monitored anesthesia 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)**