

Health Decisions, Inc.

PO Box 110
Keene, TX 76059
P 972-800-0641
F 888-349-9735

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left Transforaminal Epidural Steroid Injection w/ IV Sedation under Fluoroscopy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Board Certified Anesthesiologist with over 9 years of experience including Pain Management.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adversedeterminations 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]:

This is a male who was injured on XX/XX/XX after lifting antennas at work. He was diagnosed with a Lumbar strain. The patient was treated with a Medrol Dosepak and 14 visits of PT as of XX/XX/XX. However the therapy provided minimal relief. An MRI of the lumbar spine dated XX/XX/XX revealed mild degenerative findings at the L2-L3 levels with disc space narrowing, dehydration and mild disc bulge was noted lateralizing to the left causing foraminal stenosis. Patient has seen pain management and ESI was recommended. Request is for Left Transforaminal Epidural Steroid Injection w/ IV Sedation under Fluoroscopy

XX/XX/XX: Physical Therapy note: XX arrived at our clinic today with signs and symptoms of mechanical low back pain. Rehab will consist of manual therapy techniques, neuromuscular re-evaluation, therapeutic exercises, stabilization, and functional movement exercises. MDI: Lifting antennas at work. DOI: 11-01-12. We are optimistic to see progressive improvement over the next 1-2 months. Please contact us with any questions or concerns. The client tolerated today's treatments/therapeutic activity with moderate complaints of pain and difficulty. Progression under current plan. Re-evaluation next treatment.

XX/XX/XX: Initial Consultation note: This is a male who works as a XX. On or about XX/XX/XX, he was involved with a worker who was fairly new at the job they were moving a lot of equipment high off the ground and he ended up lifting objects that were over 100 pounds repeatedly and twisting his body and had his back basically tighten up on him. He did not think too much of it at that time. He had some difficulty finishing his work, went back up to the towers the next day and really tightened up on the following day while he was going from XX in a truck, he got so bad that he had to go to the emergency room. His pain initially was primarily in the back; however over the next day or two, it became very significant in his left anterior thigh radiating just beyond the knee along the anterolateral leg

but not to the ankle or foot. Since that time, that has persisted. He has completed about 12 or 13 physical therapy visits and had some type of intramuscular cortisone injection previously. He has never been treated for back before. On exam he has mildly positive straight leg raise on the left, which reproduces his painful symptoms just past the knee. He has some sensory changes right on the upper lateral leg just below the knee. His reflexes are 2+ and equal in both knees and ankles. Motor strength is fairly normal with just a bit of diminished strength toward exertion of the foot and ankle. Plan: Based on the location of his symptoms and the fact he has not improved with a lot of conservative therapy over six weeks, I think he may have a small disk herniation creating a mild L5 radiculopathy. This is on his left side. He has not had any imaging studies. I think MRI will be much more helpful at this point than XR he is relatively young with no prior back problems. He may be a candidate for selective Epidural injections.

XX/XX/XX: Physical Therapy note: The client tolerated today's treatment activity with mild complaints of pain and difficulty. In my professional opinion, this client exhibits a fair prognosis at the time of discharge from skilled rehabilitative therapy in conjunction with home exercise program. The client was educated regarding the discharge prognosis and related pathology. The client exhibits good understanding and is independent in home exercise program.

XX/XX/XX: Physical Therapy Discharge Summary: No further skilled care is necessary and the client is discharged. Goals and plan were discussed with patient.

XX/XX/XX: MRI Lumbar w/o Contrast Results: Impression: Mild degenerative findings at L2-L3 with disc space narrowing and dehydration. Disc bulge is mild, lateralizing to the left causing mild foraminal stenosis. Minor degenerative findings at L4-L5 and L5-S1 as described above.

XX/XX/XX: Office Visit note: History: Pt is being seen for follow up of a low back injury with radiation to his left lower extremity. He had his MRI completed. He has been on Daypro over the last few weeks and has had little resolution of the radiation down his legs, but the low back pain is about the same. I do not think that he would be a candidate for surgery or even epidural steroids at this point unless he was to have significantly worsening left lower extremity pain. Since that is resolving, we are going to switch him to a Medrol Dosepak followed by resumption of his NSAID over the next three – six weeks. In addition he has also been having elbow pain that has been overshadowed by his low back pain problem. When he had seen his therapist, they had pointed out that he had some lateral epicondylitis. Right now he is not doing any heavy lifting so use of an elbow brace is probably not required. He will continue home exercise program and will let the medications work. I have written light duty restrictions and will see him back in three weeks.

XX/XX/XX: Office Visit note: Pt is actually having more radiating pain into the posterior lateral leg and calf where initially he had a numb area and he has positive straight leg test reproducing these symptoms today. He remains tight in his back. He is having difficulty holding his child. He is not taking a lot of pain medications but certainly is not showing a lot of signs of progress, especially regarding mild radiculopathy. He has completed therapy. He just refilled his Daypro and we will complete that prescription and then plan to stop the NSAID when it runs out. Hopefully we will get both problems heading in the right direction so we can increase his work limitations since he does heavy lifting at work climbing electrical towers.

XX/XX/XX: Office Visit note: This gentleman who has hurt his back months ago basically up on a tower climbing who has persistent refractory back pain. It is more in the left side and it radiates into his posterior hip area, sometimes towards the anterior hip then goes past his knee to the anterolateral leg. He has not improved. Daypro seems to help a little bit. He has not been on pain medications but his pain level has actually increased over the past few weeks. We are going to try some tramadol. Our big problem is that we have requested pain management evaluation with possible ESI to be performed for some problems with bulging disk that is interfacing his nerve roots. We have been told that he needs to go in network but he has contacted every in network provider on their list within a reasonable radius and no one will see him. We specifically at this point would request out of network evaluation by a pain management specialist to see if they can help in some manner. I am putting him on tramadol. He can continue with Daypro on and off and he is still on work limitations at this point. Physical therapy did not help a lot and we may consider a work conditioning program. We have also given him contact information for the Injured

Employee Counsel since there have been delays and denials of the treatment so far.

XX/XX/XX: Urgent Care Visit note: This is a male that presents with back pain onset XX years ago. Location of pain is low back and radiates to the right thigh and left leg. The pt describes pain as stabbing and throbbing, symptoms are aggravated by bending and relieved by rest. This is his first visit for injury that happened in XXXX. The workup has included MRI which demonstrated a mild L2-3 Disc space narrowing and dehydration. There was also a mild bulge that was reported to be causing mild foraminal stenosis as well as two minor degenerative findings at L4-5 and L5-S1. He states that he has been in chronic pain since the accident and he has tried physical therapy which has only make his back pain worse. He has never had epidural injections and is currently not taking any medications. There is diffuse tenderness over the lower lumbar region bilaterally along the paravertebral muscle groups without radiation down the buttocks or sciatic root. There is a + straight leg test on the right but not until about 60 degrees reflexes are normal.

XX/XX/XX: Office Visit note: This is a XX year old who was referred for evaluation of low back pain now for a work related injury. The patient reports work-related injury occurred on XX/XX/XX when he was up on a south tower and felt a sudden "pop" in his lower back, possibly during a "twisting" motion while he was moving an antenna from the top of the tower. Despite the pain, he was able to climb down the tower. He reports that he made it to work the following two days and again climbed the south tower despite experiencing the significant amount of pain with these activities. His current symptoms include primarily low back pain that is more troublesome than his leg symptoms. The back pain is lateralized to the left. It occasionally radiates into the legs, with the left leg more involved than the right. In the left lower extremity, the pain radiates down the posterior thigh into the posterior and lateral knee, and into the lateral ankle. He does not feel pain radiating to his foot however. There is numbness and tingling in the same distribution including the dorsal aspect of the left foot. Problem: Chronic low back pain, status post work related injury XXXX, Myofascial pain syndrome of the lumbar spine, Lumbar facet joint syndrome, suspected to be contributing to much of his axial low back pain, Component of the chronic lumbar radiculopathy as well. Plan: Updated MRI of lumbar spine since last study was XX years ago to help determine if there is evidence of nerve root compression. May resume cyclobenzaprine 5-10mg tid PRN. We will likely refer the patient to an anesthesia pain specialist for further interventional options to treat the lumbar spine. Pt will return within two weeks for follow up. Exam: gait- steady, independent, able to walk on his toes and heels bilaterally with increased pain response when attempting to walk on heels. Straight leg raise is negative to 90 degrees in the sitting position bilaterally. Lumbar flexion is mildly limited to approximately 75 degrees secondary to pain. Lumbar extension is virtually nil. Lateral flexion to either side is done in a very guarded manner due to increased pain. Rotation to either side also results in increased pain especially when followed by extension contralaterally. Palpation of the paralumbar musculature does reveal quite a bit of muscle spasm.

XX/XX/XX: MRI Lumbar Spine without Contrast Results: Impression: Degenerative changes of the lumbar spine as described above, clinical correlation needed to determine the significance of these findings.

XX/XX/XX: Pain Management Consult: Recommendations: XX has been referred to me by his treating physician for consideration of interventional pain management. He has not yet been afforded the opportunity for interventional treatment. He has a decision order signed on XX/XX/XX stating that he has not yet reached the Maximum Medical Improvement. He has had some difficulty locating an interventional pain management physician in XX and this has caused a delay in his treatment. He is definitely a candidate for an interventional injection. He has a history of anxiety and does have some needle phobia. I believe he would require sedation for this procedure as alternatives have been discussed with him. He is in agreement with this. In an effort to reduce his pain which he has not yet had, a left L4 and L5 transforaminal epidural steroid injection would greatly be appreciated by everyone concerned especially the patient and this would expedite his access to recommended care. At this time XX will require a left L4 and L5 transforaminal ESI. This will be scheduled at the earliest possible time.

XX/XX/XX: UR: Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines, this request is not certified. There is lack of nerve root impingement on MRI and or Electro diagnostic studies reporting radiculopathy. There is lac of full exhaustion of conservative care. There is lack of severe anxiety.

XX/XX/XX: Maximum Medical Improvement/ Impairment Rating: In Summary, since last exam in XX/XX/XX claimant has gotten worse and has been frustrated with lack of care. On XX/XX/XX, XX released him stating claimant was beyond his help and expertise and on XX/XX/XX, XX wanted to do more physical therapy, which upset the claimant as he already did that without success and has trouble walking with without assistance using his cane due to severe pain with most lumbar movement. He did not have a CT myelogram done since he was looking for another Doctor to help him according to the claimant. Statutory MMI is XX/XX/XX, but determining MMI is difficulty since claimant needed diagnostic imaging and future therapy to potentially improve as stated in the last DD exam (injections/surgery) and recommended last visit on XX/XX/XX. Why these were not done I am not sure or have taken so long, nevertheless with the information documented given and based on my last exam I conclude he reached MMI on XX/XX/XX.

XX/XX/XX: UR: Based on the clinical information submitted for this review this request is non-certified. There are no indications for sedation during a routine lumbar epidural steroid injection.

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

Based on the clinical information submitted for this review this request is non-certified. There is lack of nerve root impingement on MRI and or Electro diagnostic studies corroborating radiculopathy. There is lack of full exhaustion of conservative care. There is lack of severe anxiety. There are no indications for sedation during a routine lumbar epidural steroid injection. Therefore, this request 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)**