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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Transforaminal Epidural Steroid Injection, Right SI 64483

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: American Board Certified Physician in Anesthesiology with Experience in Pain Management, with more than 10 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]:

This is a male who suffered a work related injury to his back on XX/XX/XX at work when he lifted an 85lb panel into a ditch causing him to fall. He reports severe back pain that radiates down the right leg with madness in bilat hands and feet, weakness, unsteadiness, stiffness and muscle spasms. He states he is gaining strength to his left side but worst on the right side. He reports after the injury he saw a chiropractor for 3 days in a row and after the 3rd day he got home and collapsed due to paralysis in both legs. He was hospitalized for a week and a MRI showed stenosis. He was given steroids for a week due to severe swelling and has done 12 weeks of Physical therapy after being released from the hospital. Request is for Transforaminal Epidural Steroid Injection, Right SI 64483.

XX/XX/XX: Plan of care PT note: Date of injury XX/XX/XX. Treatment diagnosis Sprain of Lumbar, Thoracic or lumbosacral neuritis or radiculitis unspecified. Pt present with S/S consistent with a R lumbar strain as evidenced by decreased lumbar ROM, tender to palpitation in R lumbar area, decreased muscle strength in Bil lower extremities. Due to pain limited ROM. Plan 2-3 times a week for 4 weeks.

XX/XX/XX: Physical Therapy Progress note: Pt continues to have pain, decreased ROM, decreased muscle strength and an antalgic gait pattern. Pt is progressing slowly in some areas but regressing in others. Pt does not appear to be adhering to HEP or HEP is not working. Pt does not appear to be a candidate for physical therapy at this time. Pt is D/C'd with HEP.

XX/XX/XX: Workers Compensation Report: Based on my examination findings, the medical records, the history and nature of the injury, my profession opinion that it is medically reasonable and probable that XX extent resulting from the injury was caused, aggravated, (accelerated, worsened or enhanced) by the concisions in the lumbar/lumbosacral area and the forces involved were a substantial contributing factor. Therefore, it is my opinion that the following conditions would be included for the extent of the injury. Myelopathy, Muscle Contusion and or

aggravation of muscle contusion, Edema or aggravation of, and Lumbosacral Neuritis and or Aggravation of same. It is in my professional opinion that based upon my education and training that the work related claimed incident caused the above injuries. I find that the injury that occurred on XX/XX/XX was a substantial contributing factor in bringing about the additional claimed injury or conditions. XX has not met MMI, I would estimate a future MMI date on or around XX/XX/XX, which would allow him time to achieve additional material recovery.

XX/XX/XX: Office Visit Note: Pt with complaint of back pain and numbness. Work related injury. No medical or surgical history. Gait: Staggering and lurching motions, using assistive device for mobility single prong cane. XX has sustained a rather serious injury requiring a one week hospital stay, MRI of T and L spine reveals "stenosis" as per notes. Exam does suggest a radiculitis and I believe an EMG of the RLE is indicated.

XX/XX/XX: Office Visit Note: Complains of Back pain and weakness. Assessment: Neurological evaluation of the upper extremities reveals no evidence of stocking or glove sensory loss and Sourling's maneuver is negative. Lower extremities reveals clonus is not noted at the ankle bilaterally. Straight leg r is positive on the right and no evidence of stocking or glove sensory loss. Hoffman reflex is not noted. Exam of the T-spine Moderate tenderness to palpation rates pain 7/10 Mid to lower thoracic spine. Exam of L-spine tenderness to palpation, pain is present (right paraspinous and buttock) abnormal strength and tone, laxity and crepitus present, paraspinous muscles spasm present, abnormal lumbosacral spine movements, abnormal posture and gait, abnormal coordination and posture and reflexes. Weakness noted along the entire right side, weakness noted on the entire left side. Weakness noted at the EHL on the right, weakness noted at the ankle dorsiflexion (right side worse than left). Discussed lower extremity EMG. EMG abnormal and consistent with denervation at L5-S1. Request submitted for MRI of the lumbar spine due to continued pain and weakness of the right leg and abnormal EMG. Previous MRI done in XX he is unsure if it was a mobile unit. Possible re-consult with XX depending on MRI outcome. Discussed pain medications with him and he is open to trying something for pain and radiating symptoms. Discussed natural medications and stressed that those can sometimes interfere. He is taking Willow Bark which is similar to aspirin or NSAID. New prescriptions given for Nortriptyline 10mg at bedtime and Ultracet for pain. He is currently not working and is unable to stand or walk without assistance of a cane. He is to consult PCP regarding elevated BP.

XX/XX/XX: Office Note: This male is seen today for complains of lumbar spine pain. Pt states he was lifting a 90 lb. wooden panel from a ditch when the edge or ditch caved in. Pt tried to push the panel forward and ended up falling backwards and landed on a rock with his back. He is on Worker's Comp. The pain is described as aching, the symptoms occur intermittently. The patient is experiencing pain in the following locations: lower back. He rates current pain 5/10. The pain radiates from his lower back then to the bilat ankles R>L. They symptoms are aggravated by walking, standing and lifting. Philip states that the symptoms are relieved by rest. MRI done at MDI. Pt is not taking any pain medications. UR Results: Four views of the lumbar spine shows loss of disc height L5-S1, mildly at other levels, no acute fracture. Pt has decreased ROM of L-spine. He is experiencing symptoms of numbness and tingling in his feet bilaterally right worse than left. He has diminished flexion of the lumbar spine. He has a diminished reflex at S1 on the right. He has weakness with plantar and dorsiflexion, in an L5 and S1 distribution. He has not had an injection at this time. Injection options discussed today. Dx: Radiculopathy of lumbar region (M54.17)

XX/XX/XX: UR: Based on the clinical information submitted this request is non-certified. Per guidelines, lumbar ESI is recommended for patients with radiculopathy that is corroborated by image studies and or electrodiagnostic testing. Aside from decreased Achilles reflex, measures to objectively document radiculopathy was not documented. Clear evidence of recent image to support physical findings cannot be verified as it was poorly scanned.

XX/XX/XX: UR: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. There was no new clinical information provided that addressed the prior reason for denial, a clear copy of the patients MRI report was not provided to support the documented physical findings

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

Based on the clinical information submitted this request is non-certified. Per ODG, lumbar ESI is recommended for patients with radiculopathy that is corroborated by image studies and or electrodiagnostic testing. Aside from decreased Achilles reflex, there is no documentation of radiculopathy. Therefore, this request is non-certified.

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)