Clear Resolutions Inc.

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DATE OF REVIEW:
AUGUST 28, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Lumbar transforaminal epidural steroid injection right L5, S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
American Board of Physical Medicine and Rehabilitation and specialized in Pain Management

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Office records Dr., 08/30/05 and 10/03/05
Medical records review by Dr., 03/17/06
MRI lumbar spine, 09/13/06
Office records, Dr. 02/06/07, 05/31/07 and 07/26/07
Office records, Dr. 06/14/07
Peer review, 07/16/07, 07/26/07
Letter by, 08/14/07

PATIENT CLINICAL HISTORY [SUMMARY]:
Record review indicates that the claimant is a gentleman who was injured on xx/xx/xx while lifting a 6 inch suction hose. Pain developed in the lower back and bilateral hips and legs. Studies later showed an L5-S1 right paracentral protrusion. Reference was made to an EMG by Dr. in xxxx which was reportedly consistent with acute L5-S1 radiculopathy. He eventually underwent a fusion procedure by Dr. sometime in October of 2005. He was

later seen by Dr. for pain management. He has been maintained on opioids. An MRI from 09/13/06 showed broad based central to right paracentral disc protrusion at L5-S1 abutting the nerve root but no mass effect on the right S1 root. He continued to follow with Dr. the last note being July 26, 2007. The claimant reported his pain levels to be from an 8 to a 3 while using the MSIR 30 mg. He used 4 ½ per day. He was able to work and function as a result of taking the medication. He performed physical labor. He had difficulty with libido. Neurologic exam indicated reflexes in the knees were 3+ and he had positive leg raises at 60 degrees bilaterally. Assessment was lumbar disc disease, post-op with chronic daily pain responding to low dose morphine.

He was seen by Dr., M.D. on June 14, 2007 referred by a Dr. He presented with back pain noting visual analog pain scale of 8 to 9 currently and 3 to 4 when he was on pain medication. He noted pain radiating to the right buttock and right posterior thigh, constant severe, sharp, and throbbing. Physical examination noted decreased lumbar range of motion. Deep tendon reflexes were noted to be symmetrical with 2 out of 4 left and right Achilles tendon jerks. Strength was intact. There was a positive right straight leg raise test. It does not look like facet loading and maneuvers were done, however he suggests right L3 to S1 facet median nerve blocks. It is not clear why now review is being done for lumbar transforaminal injections right L5 and S1.

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

Based on the ODG guidelines, particularly point 1 involving documentation of radiculopathy and point 2 unresponsiveness to conservative treatment; it does not appear that transforaminal injections at L5 or S1 are medically necessary. Therefore, the Reviewer would uphold the previous denials.

Looking at the criteria for the use of epidural steroid injections, point 1 states that radiculopathy must be documented by objective findings. In this case there are no objective findings of muscle weakness, reflex loss, atrophy, or MRI findings suggesting nerve root compromise. Point 2 states that the pain should be unresponsive to conservative treatments including medications. In this case it appears that he is being managed by the current medications to the extent that he is able to function and work at a laboring job. It is also noted that when using epidural steroid injections for chronic pain greater than 6 months, success is decreased three fold if duration of symptoms is greater than 24 months. Indications for repeating injections in a patient with chronic pain at a level previously injected include a symptom free interval or indication of a new clinical presentation at that level.

Official Disability Guidelines: 2007 Updates; Low back

Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition.
Short-term symptoms: The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. (Armon, 2007) Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little

information on improved function. There is no high-level evidence to support the use of epidural injections of steroids, local anesthetics, and/or opioids as a treatment for acute low back pain without radiculopathy. (Benzon, 1986) (**ISIS, 1999**) (**DePalma, 2005**) (Molloy, 2005) (Wilson-MacDonald, 2005)

Use for chronic pain: Chronic duration of symptoms (> 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months. (Hopwood, 1993) (Cyteval, 2006) Indications for repeating ESIs in patients with chronic pain at a level previously injected (> 24 months) include a symptom-free interval or indication of a new clinical presentation at the level.

Transforaminal approach: Some groups suggest that there may be a preference for a transforaminal approach as the technique allows for delivery of medication at the target tissue site, and an advantage for transforaminal injections in herniated nucleus pulposus over translaminar or caudal injections has been suggested in the best available studies. (Riew, 2000) (Vad, 2002) This approach may be particularly helpful in patients with large disc herniations, foraminal stenosis, and lateral disc herniations.

Criteria for the use of Epidural steroid injections:

(1) Radiculopathy must be documented. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. (Andersson, 2000)

(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) 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 two injections should be performed. A second block is not recommended if there is inadequate response to the first block. 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. To be considered successful after this initial use of a block/blocks there should be documentation of at least 50-70% relief of pain from baseline and evidence of improved function for at least six to eight weeks after delivery.

(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) In the therapeutic phase (the phase after the initial block/blocks were given and found to produce pain relief), repeat blocks should only be offered if there is at least 50-70% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)

(8) Repeat injections should be based on continued objective documented pain 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 as this may lead to improper diagnosis or unnecessary treatment.

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)