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Notice of Independent Review Decision

DATE OF REVIEW: 12-15-08

IRO CASE #:

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

This case was reviewed by a Pain Management, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right L4 and right S1 transforaminal epidural steroid injection

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o May 5, 2007 Lumbar MRI read by Dr,
- o July 3, 2008 Follow-Up Evaluation from Dr
- o July 10, 2008 Neurosurgery consultation report from Dr
- o October 27, 2008 Pain Management Consultation from Dr. [p. 2 of 3 pp is lacking]
- o November 3, 2008 Request for pre-certification epidural steroid injections from Dr.
- o November 4-19, 2008 Print notes from the nurse case manager,
- o November 6, 2008 Letter of non-certification for epidural steroid injections
- o November 19, 2008 Letter of non-certification for appeal, epidural steroid injections
- o November 25, 2008 Request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records available for review, the patient is a xx-year-old employee who sustained an industrial injury to the low back on xx/xx/xx when he fell approximately 14 feet from a ladder. He developed low back pain that radiates to his lower extremities.

Lumbar MRI of May 5, 2007 shows a "central disc protrusion at L5-S1. There is loss of disc space at that level and disc dessication. The other discs are normal. The protrusion at L5-S1 causes mild flattening of the anterior aspect of the thecal sac. "It does not abut the nerve roots nor cause significant canal compromise."

The patient was seen in follow up on July 3, 2008 for medication refill. He reports continuing moderately severe low back pain worsened with coughing and sneezing and daily activities. He reports continued weakness in the lower extremities, especially on the left. He will see a neurosurgeon next week.

A neurosurgery consultation was provided on July 10, 2008. The patient reports low back pain with radiation to the lower extremities associated with numbness and tingling, right more than left with weakness and claudication. He does not use an assistive device for walking. He reports falling on several occasions. He is 6' 6" and 173 pounds. He demonstrates antalgic gait.

Patellar jerk is hypoactive bilaterally. He has decreased sensation in the bilateral L5 dermatomes and decreased vibratory sense in the bilateral lateral malleolus. Lumbar flexion is to 90 degrees with pain and extension is to 15 degrees. Straight leg raise elicits pain at 30 degrees on the right and 45 degrees on the left. The diagnosis is lumbosacral radiculopathy and L5- disc herniation. He has had extensive treatment with medications, analgesics, muscle relaxants, anti-inflammatory medications, anti-depressants and he is currently using Norco 10/325 and Celebrex 200 mg. He has been provided 2 epidural steroid injections and trigger points as well as two sessions of physical therapy which have not provided significant benefit. He should have additional conservative treatment of repeat bilateral selective nerve root blocks at L5 bilaterally.

The patient was provided a pain management consultation on October 27 2008. The patient continues with low back pain and shooting radicular symptoms since his injury of over 2 years prior. He reports a pain level of 8/10. He uses about 15 tablets of hydrocodone weekly. He reports numbness and tingling into the legs, right worse than left. He reports total hypoesthesia on his posterior right leg and across his right anterior thigh down to the medial calf. He reports subjective weakness, especially in the right leg and he has fallen several times. He cannot sit or stand very long without increased symptoms. He has not improved significantly with physical therapy, epidural injections. He was considered for a spinal cord stimulator. He has been recommended since July 2008 for a repeat trial of epidural steroid injections. The patient is tender over the lumbar facet joints at L4-5 and L5-S1 and his iliolumbar musculature. Right straight leg raise elicits excruciating pain down his posterior leg into his calf at about 20 degrees. Straight leg raise on the left elicits pain in the right leg. He has low back pain with bilateral leg radiculopathy, right much worse than left. L5-S1 disc protrusion flattening on the anterior aspect of the thecal sac. Signs and symptoms of L4-S1 radicular pain. He has not had epidural injections for one year. He is not a surgical candidate due his young age per his surgeon. He has mainly right nerve root irritation at L4-S1 and would benefit from transforaminal epidural steroid injections to those levels.

Request for lumbar epidural injections were not certified in review on November 6, 2008 with rationale that the patient had 3 ESIs a year ago with no relief. His pain MD then suggested a spinal cord stimulator which confirms that epidural injections did not help. There is no clinical support to repeat a failed procedure. ODG's procedure summary for chronic pain states that indications for repeating ESIs in patients with chronic pain at a level previously injected (greater than 24 months) include a symptom-free interval or indication of a new clinical presentation at the level. In the peer-to-peer discussion the provider stated he did not know the patient had a poor past response to ESIs. When such was pointed out in the pertinent report, the provider concurred.

On November 13, 2008 a separate request for ESI at bilateral L5 level only was certified in review with rationale that while the MRI found no nerve root encroachment by the protruding disc the patient has clinical radiculopathy per several examiners. It was noted that this request is for ESI at the dermatomal level where the radiculopathy is found on examination and appears reasonable.

Request for reconsideration for right L4 and right S1 transforaminal epidural steroid injection was not certified in review on November 18, 2008 with rationale that the lack of response to ESI in 2007 suggests he will not benefit from further attempts. The claimant does not meet the current criteria for the requested procedure. In peer-to-peer discussion the provider concurred that the patient had a prior poor outcome with epidural injections.

The provider responds with request for an IRO.

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

The patient has a central disc protrusion at L5-S1 per MRI that does not abut the nerve roots nor cause significant canal compromise. The other discs are normal. The patient has radiculopathy clinically, right worse than left. An MRI report noting L5-S1 disc protrusion is not found. The patient has had at least 2 epidural injections one year prior without significant benefit. The patient has been certified ESI at the bilateral L5 per a separate request which notes that L5 is the level where clinical radiculopathy is found. The patient does not meet guideline criteria for right L4 and right S1 transforaminal epidural steroid injection. Therefore, my determination is to agree with the previous non-certification of the request for right L4 and right S1 transforaminal epidural steroid injection.

The IRO's decision is consistent with the following guidelines:

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

 X 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

The Official Disability Guidelines: Low Back - 12-3-2008:

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. 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 or return to work. 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. The ideal time of either when to initiate treatment or when treatment is no longer thought to be effective has not been determined. (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) (Young, 2007) This approach may be particularly helpful in patients with large disc herniations, foraminal stenosis, and lateral disc herniations. (Colorado, 2001) (ICSI, 2004) (McLain, 2005) (Wilson-MacDonald, 2005)

Fluoroscopic guidance: Fluoroscopic guidance with use of contrast is recommended for all approaches as needle misplacement may be a cause of treatment failure. (Manchikanti, 1999) (Colorado, 2001) (ICSI, 2004) (Molloy, 2005) (Young, 2007)

Factors that decrease success: Decreased success rates have been found in patients who are unemployed due to pain, who smoke, have had previous back surgery, have pain that is not decreased by medication, and/or evidence of substance abuse, disability or litigation. (Jamison, 1991) (Abram, 1999) Research reporting effectiveness of ESIs in the past has been contradictory, but these discrepancies are felt to have been, in part, secondary to numerous methodological flaws in the early studies, including the lack of imaging and contrast administration. Success rates also may depend on the technical skill of the interventionalist. (Carette, 1997) (Bigos, 1999) (Rozenberg, 1999) (Botwin, 2002) (Manchikanti, 2003) (CMS, 2004) (Delpont, 2004) (Khot, 2004) (Buttermann, 2004) (Buttermann2, 2004) (Samanta, 2004) (Cigna, 2004) (Benzon, 2005) (Dashfield, 2005) (Arden, 2005) (Price, 2005) (Resnick, 2005) (Abdi, 2007) (Boswell, 2007) Also see Epidural steroid injections, "series of three" and Epidural steroid injections, diagnostic. ESIs may be helpful with radicular symptoms not responsive to 2 to 6 weeks of conservative therapy. (Kinkade, 2007) Epidural steroid injections are an option for short-term pain relief of persistent radiculopathy, although not for nonspecific low back pain or spinal stenosis. (Chou, 2008) As noted above, injections are recommended if they can facilitate a return to functionality (via activity & exercise). If post-injection physical therapy visits are required for instruction in these active self-performed exercise programs, these visits should be included within the overall recommendations under Physical therapy, or at least not require more than 2 additional visits to reinforce the home exercise program.

With discectomy: Epidural steroid administration during lumbar discectomy may reduce early neurologic impairment, pain, and convalescence and enhance recovery without increasing risks of complications. (Rasmussen, 2008)

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, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

(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) 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 required. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of 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.)