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Notice of Independent Review Decision

DATE OF REVIEW: January 23, 2008

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 physiatrist, 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

Lumbar selective epidural steroid injection, left L4

REVIEW OUTCOME

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

Overtured (Disagree)

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 December 28, 2007 progress note by M.D.
- o October 3, 2006 report from M.D.
- o October 17, 2005 through October 3, 2006 work status reports from M.D.
- o October 3, 2006 patient questionnaires signed
- o October 3, 2006 billing records from M.D.
- o December 6, 2005 electrodiagnostic report by M.D.
- o October 17, 2005 independent medical examination report by M.D.
- o October 17, 2005 patient questionnaires signed
- o October 17, 2005 billing records by M.D.
- o November 15, 2005 lumbar spine MRI report by M.D.
- o November 28, 2007 patient questionnaires
- o December 28, 2007 chart notes from M.D.
- o December 9, 2008 utilization review report
- o January 2, 2008 utilization review report

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient sustained an industrial injury involving the cervical and lumbar spine. A request for a lumbar epidural steroid injection was reviewed on January 2, 2008 and a non-certification was rendered. The utilization review report states that the patient was injured when she was attacked from behind by an aggressive client, fell over the sofa, and landed on the floor. An epidural steroid injection had been administered in 2005 and was reportedly successful. An MRI from 2001 showed moderate central canal stenosis at L4-5 due to a disc protrusion. There was a non-related 1999 L5-S1 fusion. The physician reviewer rendered a denial as he opined that the case did not meet the definition of radiculopathy per the recent notes.

On January 9, 2008, the case was reviewed again and the request was non-authorized. This peer review report states that while there appears to be decreased sensation in the L4 dermatome, pain in this distribution does not appear to be of new onset, and is similar to that described in 2005. The exact level of epidural steroid injection performed and the duration of pain relief had not been provided. The report notes that a lumbar injection was authorized on August 21, 2007. A repeat request was denied on December 20, 2007. It was noted that the L4 selective block had been helpful, but percentage of relief and duration were not given. The physician opined that there was insufficient documentation to approve this request. The report states that there is no evidence of L4 involvement outside of subjective sensory loss.

A lumbar spine MRI was performed on November 15, 2005 with an impression of moderate central canal stenosis present at L4-5 secondary to concentric annular disc protrusion and bilateral ligamentum flavum hypertrophy. There is also mild central canal stenosis present at the T11-12 vertebral level best seen on the sagittal images. There is a bright T1, bright T2 structure seen in the mid L5 vertebral body extending to the inferior endplate which is probably a vertebral body hemangioma according to the report. There is also a similar finding present in the inferior aspect of the vertebral body of L3.

Chart notes from December 28, 2007 state that the patient has a left lumbar radiculopathy which had previously been successfully treated with a left L4 selective nerve root block and pulsed radiofrequency. A recent L4-5 epidural steroid injection had helped somewhat with her low back and leg pain. It mainly helped her left lower extremity pain, with only mild benefit to her low back pain. Just recently her left lower extremity started hurting again. Pain tends to travel down the left L4 distribution. Examination findings include slightly decreased sensation to touch in the left L4 distribution, 5/5 motor strength, symmetric deep tendon reflexes, ability to heel/toe walk, and negative straight leg raise bilaterally. A left L4 selective epidural steroid injection was recommended at least one more time to see if it does get better pain control. If it does not adequately control the patient's back and leg pain, the physician stated that there is a need to determine exactly how much of her pain is both facet and/or disc related for possible surgical consideration.

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

According to the Official Disability Guidelines, 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. The last lumbar epidural steroid injection was administered at the L4 level in approximately August 2007. The December 28, 2007 report noted that the patient had experienced good relief, primarily of her left lower extremity pain, which had just recently started hurting again. The pain was noted to travel to the left L4 distribution and the patient had mildly decreased sensation in the L4 dermatomal pattern. These factors meet the criteria for both radiculopathy and appropriate quantity/duration of relief for a repeat injection. Therefore, my determination is to overturn the previous non-certification of a lumbar selective epidural steroid injection, left L4.

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

Official Disability Guidelines (2008):

Epidural steroid injections (ESIs), therapeutic:

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) (Delport, 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) 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.

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and 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) 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 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 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.