

SENT VIA EMAIL OR FAX ON
Nov/19/2008

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An Independent Review Organization

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DATE OF REVIEW:

Nov/18/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Epidural Steroid Injection under Fluoroscopic Control with Epidurogram

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

Subspecialty Board Certified in Electrodiagnostic Medicine

Residency Training PMR and ORTHOPAEDIC SURGERY

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

Denial letters 10/3/08 and 10/21/08

SOAP Notes 3/24/08 thru 10/6/08

Record from Dr. 9/19/08

Records from Manangement 3/14/08 thru 10/27/07

Record from Dr. 7/2/08

Record from Neurodiagnostic Associates 6/5/08

MRI 4/30/08

Record from Injury Clinic ??/19/08

PATIENT CLINICAL HISTORY SUMMARY

This xx year old man was involved n a MVA on xx/xx/xx. An MRI on 4/30/08 showed a minimal annular bulge at L5/S1 and a conjoined right l5/S1 nerve root. He was noted on several examination to have normal neurological examinations including motor strength, reflexes and sensation He had two normal EMGs on 6/5/08 and on 9/30/08. Both Dr. and Dr. described back pain without lower extremity radicular pain.

Dr. Designated Doctor examination described no motor or sensory loss, tenderness or spasms on the lower back and lower extremity examination. Straight leg raising, reflexes and sensory examination were reported to be normal bilaterally. There was no thigh or calf atrophy. He did have reduced lumbar flexion, but increased extension and lateral flexion. Dr. did advise a lumbar epidural injection.

Dr. described back pain and no radicular pain in the lower extremities. He did described bilateral positive SLR at 50 degrees, bilateral positive Braggards, Kemp, Naclas and Ely's signs. He described reduced L4 and L5 bilateral sensation and bilateral 4+ iliopsoas flexion.

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

The ODG is specific that there needs to be radicular complaints. None were described. Dr. described some neurological findings, but bilateral signs would suggest a large central disc to effect both sides and nerve roots. The MRI was normal. The two emgs were normal. EMG limitations do exist in that they check motor and not sensory findings.

They were over used for nonspecific back pain or strains that failed to improve. They are not without risk. There are guidelines established based upon the review published by the of Neurology. This sometimes conflicts with the experience of some invasive pain doctors. The ODG relies more on the AAN criteria. Further, the MRI can be oversensitive in identifying nonspecific abnormalities in the spine. Yet none of the findings identified on MRI would be considered a possible pain generator. There must be radicular symptoms to be considered for an epidural injection. None were described. There must be neurological findings, and these are conflicting in the examinations. Again, the MRI and EMGs were normal. Although this man has ongoing pain, he does not meet the criteria established for therapeutic epidural injections. Further, there is no ambiguity on the examinations vs the radiological study to warrant a diagnostic selective root injection.

Epidural steroid injections (ESIs), therapeuti

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

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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.)

Epidural steroid injections, diagnosti

Recommended as indicated below. Diagnostic epidural steroid transforaminal injections are also referred to as selective nerve root blocks, and they were originally developed as a diagnostic technique to determine the level of radicular pain. In studies evaluating the predictive value of selective nerve root blocks, only 5% of appropriate patients did not receive relief of pain with injections. No more than 2 levels of blocks should be performed on one day. The response to the local anesthetic is considered an important finding in determining nerve root pathology. (CMS, 2004) (Benzon, 2005) When used as a diagnostic technique a small volume of local is used (<1.0 ml) as greater volumes of injectate may spread to adjacent levels. When used for diagnostic purposes the following indications have been recommended

1) To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous,

including the examples below

- 2) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;
- 3) To help to determine pain generators when there is evidence of multi-level nerve root compression;
- 4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive
- 5) To help to identify the origin of pain in patients who have had previous spinal surgery.

MRI's (magnetic resonance imaging)

There is controversy over whether they result in higher costs compared to X-rays including all the treatment that continues after the more sensitive MRI reveals the usual insignificant disc bulges and herniations. (Jarvik-JAMA, 2003)...Imaging studies are used most practically as confirmation studies once a working diagnosis is determined. ...Diagnostic imaging of the spine is associated with a high rate of abnormal findings in asymptomatic individuals. Herniated disk is found on magnetic resonance imaging in 9% to 76% of asymptomatic patients; bulging disks, in 20% to 81%; and degenerative disks, in 46% to 93%.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES

(PROVIDE A DESCRIPTION)