US Decisions, Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 18, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for Lumbar ESI #2 L4-5.

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

MD, Board Certified Orthopedic Surgeon

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for Lumbar ESI #2 L4-5.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Prescription for physical therapy, 03/14/08
Physical therapy evaluation/Care Plan, 03/17/08
Office note, Dr. , undated
MRI lumbar spine, 05/19/08
Office notes, Dr. , 06/19/08, 07/28/08
Radiology report, 06/19/08
Operative report, 07/07/08

Request for ESI, 07/24/08
Request for lumbar ESI, 07/26/08
Review, Dr. , 08/06/08
Review, Dr , 08/19/08
Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, (i.e. Low Back-Epidural Steroid Injections)

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx year-old male was injured on xx/xx/xx when he slipped and fell in the mud. He treated for a sprain/strain of the lumbar spine with left low back and radicular pain to the left heel. Dr. evaluated the claimant on an unknown date with minimal tenderness in the lumbosacral spine, improving motion and left leg spasm. There were no focal deficits. Lodine, Flexeril and therapy were recommended by Dr. . A lumbar MRI on 05/19/08 revealed a large disc herniation at L4-5 which affected the thecal sac and both spinal nerves although more so on the left than right. The canal was also stenotic at this level. There was an asymmetric right disc protrusion at L5-S1 affecting the right L5 nerve, a mild disc bulge noted at L3-4 without evidence of impingement upon the thecal sac or exiting spinal nerves. There was diminished T2 signal in discs L3-4, L4-5 and L5-S1 indicative of desiccation and degeneration.

Dr. evaluated the claimant on 06/19/08 for left sided leg pain mainly and paresthesias. His pain was essentially in the left leg mainly in the left lateral aspect of the leg with paresthesias in the dorsal aspect of the foot. He was taking Hydrocodone. There was decreased sensation in the L5 distribution on the left. Left leg radiculopathy due to an L4-5 herniation was diagnosed. Lumbar x-rays on 06/19/08 showed: in AP, his psoas shadows were symmetric bilaterally. There were 5 mobile lumbar segments. The SI joints showed no significant arthrosis and the hip joints as well did not show any significant arthrosis. There was no evidence of posterior element disease and the facet joints appeared to be with just very minimal arthrosis at L4-5. On lateral view, there appeared to be some disk height loss at L5-S1. There were no signs of instability or spondylolisthesis on the dynamic views.

On 07/07/08 the claimant underwent a caudal epidural steroid injection which provided some reported improvement. The claimant was seen on 07/28/08 by Dr. with ongoing left calf pain. Tension signs were mildly positive on the left side and he complained of paresthesias in the left calf. A second lumbar epidural steroid injection was recommended. This was denied on two peer reviews dated 08/06/08 and 08/19/08 and is currently under dispute.

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

This request for a second epidural steroid injection is not indicated or appropriate according to ODG criteria. This is a xx year-old who has undergone one epidural steroid injection on 07/07/08. Notably on 07/28/08 he had followed up and had some improvement, but still with persistent left calf pain and paraesthesias in the left calf and mildly positive neurotensions signs with normal strength. An MRI on 05/19/08 demonstrated a large disc herniation at L4-5.

Given the fact that there is no objective quantification of this improvement, the reviewer does not think that a repeat epidural steroid injection is appropriate. There is also controversy about

the timing of these, and the reviewer agrees with the guidelines that after three months it is not beneficial.

As such, based upon these medical records, and the ODG Guidelines (included below) the reviewer does not think that it is indicated or appropriate for a second epidural steroid injection.

The reviewer finds that medical necessity does not exist for Lumbar ESI #2 L4-5.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, (i.e. Low Back-Epidural Steroid Injections)
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) 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.

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) 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 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)