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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/21/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

62311 Lumbar Epidural Steroid Injection

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Adverse Determination Letters, 2/17/09, 3/6/09

Employer's First Report of Injury, xx-xx-xx

Office note, Dr, 03/04/08, 06/03/08, 06/17/08, 07/01/08, 07/03/08, 07/17/08, 09/02/08, 10/02/08, 10/16/08, 10/28/08, 11/24/08, 12/09/08, 12/31/08, 01/29/09, 02/20/09, 03/04/09

X-rays cervical spine, 03/04/08

X-rays lumbar spine, 03/04/08

RTW note, 03/11/08

MRI lumbar spine, 04/11/08

MRI cervical spine, 04/30/08

Electromyography studies, 05/05/08

Office note, Dr., 06/17/08

Office notes, Dr., 07/10/08, 10/30/08

RTW activity prescription, 07/31/08

Supplemental Report of Injury Form, 08/01/08

Review, Dr., 08/27/08

Office notes, Dr. 11/25/08, 12/30/08, 02/10/09, 02/24/09

Review, 02/17/09, 03/06/09

Daily Physical Therapy Notes, 04/10/08, 04/15/08, 06/26/08, 07/08/08, 07/17/08, 07/31/08,

MRI Right Shoulder, 04/11/08

X-rays right shoulder, 03/04/08

PATIENT CLINICAL HISTORY SUMMARY

This female claimant slipped on batteries and fell backwards landing on her tailbone and low back on xx-xx-xx. Her history was significant for smoking and type II diabetes. Dr. saw the claimant on 03/04/08 for various complaints including low back and right leg symptoms. She walked very slowly and carefully, could heel/toe walk and tip toe stand with difficulty causing low back pain, tenderness of the spinous processes, supraspinatus ligaments, paravertebral muscles from C6-7, T1-6 and L1-S1, positive Spurling's, tenderness to palpation of the SI joint on the right, positive flip test bilaterally more painful on the right, positive Lasegue on the right, forcible dorsiflexion of the foot caused right low back pain, Patrick was positive bilaterally, more painful on the right. Strength was 4 on the right lower extremities. Reflexes were normal and lumbar flexion and extension decreased. Sprain/strain of the cervical and lumbar spines and right rotator cuff tendonitis were diagnosed. Therapy, plain x-rays, off work and Vicodin and Skelaxin were recommended. Lumbar x-rays on 03/04/08 showed bony spondylosis and questionable disc space narrowing at L4-5.

A lumbar MRI on 04/11/08 showed a moderate posterior central (subligamentous) disc protrusion at L4-5 and slight diffuse posterior bulging disc of L3-4 and L5-S1. On 06/03/08 the claimant reported pain with numbness in the lumbar region to the right foot. The examination showed tenderness to palpation of the SI joints bilaterally, 1+ reflexes throughout the upper and lower extremities on the right. The examination was otherwise unchanged. Lumbar and cervical herniated nucleus pulposus were added to her diagnoses. Therapy and referral to Dr., orthopedic surgeon were advised.

Dr. saw the claimant on 06/17/08 for low back pain without radicular complaints. There was tenderness with spasm, normal ankle and knee jerks, no sensory deficit or atrophy in the lower extremities and normal leg raising and sensory in the lower extremities. Dr. stated that the claimant's symptoms were compatible with resolving cervical and lumbar sprains and a protrusion of the central disk at L4-5.

Dr. examination on 07/03/08 showed an abnormal gait due to increased lumbar pain, pain with tandem walk, the ability to heel/tip toe stand with increased lumbar pain, tenderness of the spinous processes, supraspinatus ligaments and paravertebral muscles from C6-7, T1-6 and L1-S1, positive Spurling's, tenderness to palpation of the lumbar region, 4-5 bilateral lower extremity strength and normal reflexes. Soma and Vicodin were prescribed.

Dr. saw the claimant on 07/10/08 at which time there was pain of the paraspinals, predominantly L2-3 and L3-4, globally decreased flexion, extension, side bending and rotation and some radiculopathy occasionally down the right leg. A herniated nucleus pulposus at L4-5 was diagnosed. Core strengthening program, lumbar epidural steroid injections if therapy did not help were advised. Dr. examination on 07/17/08 noted 1+ reflexes of the upper and lower extremities on the right and was otherwise unchanged.

On 09/02/08 the claimant had lumbar pain radiating to the right leg. There was limited active motion with pain and numbness. She was to continue light duty, Soma and Vicodin. On 10/16/08 he had 4 right lower extremity strength. Dr. re-evaluated the claimant on 10/30/08 noting her to be predominantly tender over L4-5, globally decreased motion, a positive straight leg raise to 45 degrees, radiculopathy going down the legs and good strength. She was referred to Dr. for possible surgery. She was to hold off on steroid injections due to her diabetes and continue anti-inflammatories.

On 11/25/08 the claimant presented to Dr. noting a disk herniation and lower lumbar spine symptoms for approximately 9 months despite therapy. She had low back pain with radiculopathy worse on the right lower extremity and night pain in the lower extremities consistent with diabetic neuropathy. Her pain was worse on the plantar surface of her feet, had a pins and needles and tingling ad her bed sheets bothered her. She reported frequent

falls and right lower extremity weakness without giving way. Dr. stated the lower extremity examination was somewhat nonconsistent with her MRI. She had approximately 4-/5 strength from the L2-S1 nerve distribution bilaterally and tenderness to palpation along the entire thoracic and lumbar spine. Dr. recommended Lyrica and Amrix. He re-evaluated the claimant on 12/30/08 for ongoing back pain going down the right leg with numbness and tingling. There was a positive straight leg raise on the right. The motor and sensory examination was otherwise intact. She had decreased motion with pain. An epidural steroid injection was recommended. This was denied on two reviews and is currently under dispute. Dr. stated that the procedure was denied do to neuropathy on EMG. Dr. stated the claimant had back and right leg pain and recommended EMG and a CT myelogram.

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

Epidural steroid injection is not indicated and appropriate in this female who had an injury date of 03/03/08. She has a medical history of diabetes. On 11/25/08 there is noted lower extremity exam that was not consistent with her MRI. On her MRI there was noted to be a disc herniation at L4-5.

As per the ODG, epidural steroid injections are best suited for acute and subacute radicular complaints. The records indicate this is a chronic complaint which has not been aggravated or exacerbated within the medical records. In addition with the preexisting diabetes mellitus the records indicate there may be evidence of peripheral neuropathy which may have a role within this and EMG's were ordered on 02/24/09. The results of the EMG are not noted within the records as of yet. Based upon this information epidural steroid injections are not indicated and appropriate. The reviewer finds that medical necessity does not exist for 62311 Lumbar Epidural Steroid Injection.

Official Disability Guidelines Treatment in Worker's Comp 2009 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 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)

An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy. (Staal-Cochrane, 2009) Recent studies document a 629% increase in expenditures for ESIs, without demonstrated improvements in patient outcomes or disability rates. (Deyo, 2009)

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.)

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)