CLAIMS EVAL

Utilization Review and
Peer Review Services

Notice of Independent Review Decision-WC

DATE OF REVIEW: 12-2-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar epidural steroid injection at L5-S1

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

American Board of Anesthesiology and Pain Medicine

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 7-14-09 DO., office visit.
- 8-12-09 MRI of the lumbar spine.
- 8-26-09 EMG/NCS performed by MD.
- 9-3-09 MD., office visit.
- 9-16-09 MD., office visit.
- Physical therapy from 9-17-09, through 10-15-09 under the direction of DO.
- 9-25-09 MD., performed a Utilization Review.
- 10-21-09 MD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

7-14-09 DO., the claimant complains of low back pain and abdomen pain. He sustained an injury on xx/xx/xx. He reported that he was pulling a dolly upstairs when he lost his balance and fell down a flight of stairs injuring his low back and abdominal region. He was initially seen at Healthworks and was not happy with the treatment there. Assessment: lumbar strain, thoracic sprain, abdomen sprain, strain, and spasms of muscle. The evaluator reported the claimant has persistent symptomatology and will be placed in a therapy program.

8-12-09 MRI of the lumbar spine shows 6mm broad right paracentral disc protrusion at L5-S1, which mildly impinges upon the thecal sac, also severely narrowing the right lateral recess. 3mm disc bulge at L1-L2, which mildly impinges upon the thecal sac, also mildly narrowing both of the lateral recesses. Mild degenerative hypertrophic spondylosis at L1-L2 and L5-S1. Moderate disc desiccation at L5-S1. Grade I spondylolisthesis at L5-S1 with 5mm of posterior subluxation of the L5 vertebra.

8-26-09 EMG/NCS performed by MD., showed bilateral L5-S1 root irritation probable lumbar radiculopathy. Mild chronic axonal injury to the right peroneal nerve (old trauma).

9-3-09 MD., the claimant is seen in consultation. The claimant reported that he slipped on a stairway with acute onset of low back pain described as constant with intermittent shooting pains into the right lower extremity associated with numbness and tingling in a non-dermatomal distribution. The claimant is status post physical therapy with no significant improvement in his symptoms. On exam, the claimant has decreased range of motion in flexion secondary to pain. Motor exam shows 5/5 strength throughout. DTR are +2 throughout and symmetrical. Plantar responses were flexor bilaterally. The claimant has no difficulty with toe or heel walking. SLR was negative bilaterally. Spurlings test was negative bilaterally. Sensory exam showed no hypoesthetic region to pinprick and light touch. The evaluator discussed treatment options from doing nothing, to continue physical therapy to epidural steroid injection with lysis of adhesions to possible surgery. The evaluator did not feel he was a surgical candidate. The evaluator recommended epidural steroid injection and a chronic pain program.

9-16-09 MD., the claimant was referred due to low back pain with numbness in both legs, worse on the right than the left. On exam, the claimant's DTR are equal and symmetric. He can heel and toe walk. SLE was negative bilaterally. The evaluator reported he reviewed the MRI and showed a disc herniation at L5-S1 extending greater right from the midline. Treatment options were discussed. He would like to proceed with a lumbar epidural steroid injection.

9-17-09, 9-18-09, 9-22-09, 9-24-09, 9-25-09, 9-28-09, 10-1-09, 10-2-09, 10-5-09, 10-13-09, 10-15-09 DO., the claimant reported that his pain has remained the same. The claimant is approved for 12 sessions of active therapy. The claimant was provided with therapy.

9-25-09 MD., performed a Utilization Review. It was his opinion that the appropriateness and the medical necessity for the performance of a Lumbar Epidural Steroid Injection at L5-S1 are not established. Upon review of medical records, the patient was diagnosed to have lumbar disc displacement, lumbar radiculitis, lumbago and lumbar myofascial injury. The medical records failed to document exhaustion of conservative measures of management namely Physical Therapy and its progress notes, medications and exercise. Absence of this documentation may preclude the performance of the said procedure.

10-21-09 MD., performed a Utilization Review. It was her opinion that the claimant is complaining of low back pain that radiates into his bilateral lower extremities, right worse than left, with associated numbness. ODG supports the use of epidural steroid injections in patients that have failed conservative care and have objective findings of radiculopathy confirmed by imaging studies. The clinic notes submitted state that the claimant has failed conservative treatment; however, there was no physical therapy summary submitted demonstrating the progress made in therapy. Additionally, the only

medications noted that the patient has tried is Motrin and Flexeril. It is unknown whether the claimant has tried other medications. Additionally, the submitted physical exams fail to show objective findings suggesting radiculopathy. There are neurological findings but they do not correspond to a single nerve root, as there is weakness in multiple muscles tested. Radiculopathy is described as numbness and paresthesias in a dermatomal distribution and the presence of findings on imaging study itself does not make the diagnosis of radiculopathy. As the claimant does not have objective findings consistent with radiculopathy, and conservative care was not submitted for this request; the medical necessity is not established for the requested L5-S1 lumbar epidural steroid injection. Determination: Non-Certified

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

With the physical examination not demonstrating evidence of radiculopathy particularly with negative straight leg raises, the claimant does not meet the criteria for medical necessity for the L5-S1 lumbar epidural steroid injection. ODG states that epidural steroid injections are recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Therefore, the request for epidural steroid injection at L5-S1 is denied. Straight Leg Raising's maneuver can test for sciatic irritation (pain radiating to the ankle of the tested leg), but sciatic nerve irritation must be differentiated from hamstrings tightness (pain descending to the posterior thigh only).

ODG-TWC, last update 11-23-09 Occupational Disorders of the Low Back – epidural steroid injection: 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) This recent RCT concluded that both ESIs and PT seem to be effective for lumbar spinal stenosis for up to 6 months. Both ESI and PT groups demonstrated significant improvement in pain and functional parameters compared to control and no significant difference was noted between the 2 treatment groups at 6 months, but the ESI group was significantly more improved at the 2nd week. (Koc, 2009)

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) (Buenaventura, 2009) 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) There is fair evidence that epidural steroid injection is moderately effective for short-term (but not long-term) symptom relief. (Chou3, 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- 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)**