



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 12-7-09 (AMENDMENT DATED 12-14-09)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left transforaminal L3-L4 lumbar spine epidural steroid injection

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

- 2-22-08 MD., office visit.
- 2-22-08 X-rays of the lumbosacral spine with flexion and extension views.
- 5-29-08 MRI of the lumbar spine.

- 5-19-08 MD., office visit.
- 6-19-08 MD., office visit.
- 7-1-08 Pain Institute - office visit.
- 9-4-09 Pain Institute - office visit.
- 9-11-09 X-rays of the cervical spine.
- 9-18-09 Pain Institute - office visit.
- 10-2-09 Pain Institute - office visit.
- On 10-5-09, MD., performed a Utilization Review.
- 10-6-09 - Pain Institute - Appeal for denial of transforaminal epidural steroid injection.
- On 10-14-09, MD. performed a Utilization review.

PATIENT CLINICAL HISTORY [SUMMARY]:

2-22-08 MD., the claimant in seen followup after having undergone plain radiographs of the lumbosacral spine as well as both hips and pelvis. The history suggests increased discomfort over the lateral aspect of the hip in association with being in an upright position as well as turning in bed at night from either the right or left side. There are no radicular symptoms. Occasionally, he will have a just different sort of feeling but not clearly numbness involving the upper posterolateral buttock and thigh with no clear-cut extension into the leg proper. On examination today, the reflexes were 1+ and symmetric at the knees and absent at the ankles even with reinforcement. There was some discomfort elicited with internal rotation of the left hip joint today. This was less apparent in terms of external rotation. Straight leg raising was negative bilaterally, No focal motor deficits was appreciated. His sensation was normal except for residual related to his previous surgery distal to the knee in a mixed L5-S1 distribution. Diagnostic studies demonstrated a solid fusion from L4 through the sacrum. His alignment was normal. He did have evidence of some slight abnormal movement at L3-L4 his last mobile segment. This is accentuated in flexion and essentially is near normal in neutral and extended positions. There were marginal osteophytes present at the L3-L4 level. There was no significant decrease in disk space height. His radiographs of the hips demonstrate a slight degree of sclerosis involving the acetabulum on the left in its lateral aspect. The joint space itself -was well preserved. The evaluator recommended referral to Fr. Lutz in consideration of a diagnostic and potentially therapeutic steroid injection at the level of the left hip joint. The evaluator recommended an Ultram ER.

2-22-08 X-rays of the lumbosacral spine with flexion and extension showed status post posterior fusion and laminectomy at L4-S1. No acute process.

MRI of the lumbar spine dated 5-29-08 showed postoperative changes without recurrent or new disc herniation at the L4-L5 and L5-S1 levels within the limitations of the ferromagnetic artifacts noted. Moderately severe central spinal stenosis at L3-L4 probably mostly due to interval facet degenerative and dorsal ligamentous thickening. Mild to moderate central spinal stenosis at L2-L3, which appears worse than on the previous study.

5-19-08 MD., the claimant continues with persistent left lumbosacral spine with some extension toward the hip. The claimant takes Hydrocodone on a regular basis to decrease his symptoms. The evaluator recommended an MRI of the lumbar spine. He was given samples of Arthrotec and a prescription for Soma.

6-19-08 MD., the claimant is seen after having undergone MRI of the lumbar spine. There have been no acute changes in symptomatology. His pain has been better controlled with a combination of both Vicodin as well as Soma. On exam, there were no tension root signs on the left, although the claimant was elicited left sided back discomfort with 90 degrees of hip flexion with the knee extended on the left. There was a slight decrease in the left patella reflex compared to the right (trace versus 1+). The ankle reflexes were trace with reinforcement only. There was no evidence of myelopathy. Strength was normal. Range of motion was restricted in all planes. The evaluator recommended referral to Dr. for pain management in addition to outpatient physical therapy to develop a home exercise program.

7-1-08 Pain Institute - the claimant has failed conservative care with medications, surgery in 2004. He still has pain and numbness at the left lower extremity. A CT myelogram/MRI showed stenosis at L3-L4 with disc bulge on the left with left nerve root compression. On exam, the claimant has decreased sensation at left L5-S1 distribution. There is weakness 4+/5 at left quadriceps at EHL flexion. The claimant has a positive Patrick's test on the left. There was no tenderness to palpation at the spine paraspinal. Impression: New L3-L4 HNP with lumbar radiculopathy and spinal stenosis. The evaluator recommended the claimant continue with medications with Dr. He recommended left L3-L4 transforaminal epidural steroid injection.

9-4-09 Pain Institute - the claimant reports numbness in the left leg. He also reports neck pain, left and arm numbness. The evaluator recommended a cervical x-rays, transforaminal epidural steroid injection. The claimant is provided with a prescription for Neurontin.

9-11-09 X-rays of the cervical spine shows degenerative bone and disc changes most prominent at C6-C7.

9-18-09 Pain Institute - the claimant's medications include Norco 10/325 and Neurontin. The claimant is to continue with his medications. The claimant reported he is still having neck pain that radiates to the shoulders and down the fingers. He reports numbness and tingling. The evaluator recommended an MRI of the cervical spine. Impression: Lumbar radiculopathy symptoms and neck pain.

10-2-09 Pain Institute - the claimant has not been able to get his MRI. He just got back in town. There are no new symptoms. The claimant is to continue with his medications, and MRI of the cervical spine.

On 10-5-09, MD., performed a Utilization Review. It was his opinion that non recommendation for approval for the repeat L3-L4 lumbar epidural steroid injection, either third or fourth for this 66 year old male, status post stated injury on 12-16-03, status post laminectomy and fusion, appears to be at L4-L5 and L5-S1 in the past, as well as physical therapy, medications, chiropractic etc. The evaluator reported he was unable to document pain relief with evidence of lasting objective improvement, unable to document that there were clear objective signs of radiculopathy. There was no clear objective evidence of neurocompression and this would not be considered to be with ODG criteria.

10-6-09 - Pain Institute - Appeal for denial of transforaminal epidural steroid injection.

On 10-14-09, MD., performed a Utilization review. The evaluator reported that based on the medical records provided, non-certification was provided. The evaluator reported that the medical records do not document a recent physical examination demonstrating clinical findings consistent with an active lumbar radiculopathy with corroborative imaging and/or electrodiagnostic study. The evaluator reported that medical records do not document when the last epidural steroid injection was obtained or detail the patient's response to the previous intervention. As noted in the references, significant pain relief for at least six weeks of at least 50% is required for a repeat injection. The evaluator reported that records do not establish the claimant had achieved this level of relief. The evaluator reported that records do not establish exhaustion of standard conservative measures, which would include physical methods and exercise.

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

Based on the medical records reviewed, I am in agreement that there is not clear evidence of lumbar radiculopathy from the levels proposed to be injected by the transforaminal epidural steroid injections. There is no indication that the claimant even had relief with the last injection. Per ODG, 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. Medical records do not reflect that the claimant met ODG criteria. Per ODG, 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) with use in conjunction with active rehab efforts. Therefore, medical necessity of the epidural steroid injection is not established.

ODG-TWC, last update 12-3-09 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) (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) (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. (Devo, 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 KNOWLEDGBASE
- 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)