



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 01/23/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4-L5 transforaminal epidural steroid injection

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

American Board of Orthopaedic Surgery-Board Certified

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

- , MD., office visits from 6-16-08 through 8-13-08 (4 visits).
- 7-18-08 MRI of the lumbar spine.
- 10-1-08 , MD., performed a Utilization Report.
- 11-19-08 , MD., performed Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

On 6-16-08, the claimant was evaluated by , MD. The evaluator noted this is a xx-year-old male complaining of pulling lumbar pain since xx/xx/xx. At that time, he was at work pulling cable off the ground when he felt a pop followed by immediate pain. The pain is intermittent but is occurring more often with a baseline the changes from zero to 8 on a scale of 10. Aggravating conditions include flexing, kneeling, lifting, driving or laying down. The claimant also complains of bilateral leg fatigueness since then the accident. The evaluator noted the claimant has not had any type of treatment to this point. On exam, he has no lumbar/sacral tenderness, spasticity or bony/soft tissue abnormality. He can bend forward to the mid-lower leg level. There is pain with forward flexion, left rotation, right side bend and left side bend. Treatment plan included conservative treatment will be attempted. If conservative treatment does not give prolonged pain relief, surgical intervention may be considered. The evaluator recommended the claimant apply ice and heat to the affected area, a home exercise program of stretching exercises of the back and legs was reviewed and will be implemented. The evaluator noted the claimant should lose weight. The anti-inflammatory medications and muscle relaxants should be taken as prescribed.

An office visit dated 7-7-08 with Dr. notes the claimant is back after attempting conservative treatment through the use of anti inflammatories and a muscle relaxant to help control his lumbar pain and his radicular symptoms. He noted that whenever he takes his medications many of his symptoms diminish, however, they are easily reproducible once the medication wears off. The claimant continues to struggle with the lumbar pain that exacerbates with activity and rotation and has a baseline that can escalate to levels of 8 on a scale of 0 to 10. The left leg radicular pain has also reached levels of 8 on a scale of 0 to 10. On exam, the lumbar spine has a guarded range of motion secondary to fear of re-exacerbation that does increase with left rotation. This pain also radiates into the left posterior thigh and lower leg. The lower extremities are motor intact with a decreased sensation along the right posterior thigh. There is a

positive left straight leg raise test and a negative bilateral Patrick's. The deep tendon reflexes are symmetrical and intact. The evaluator reported that now that the claimant has attempted conservative treatment and failed, he recommended proceeding with a lumbar MRI to visualize the spinal canal and the surrounding soft tissues.

MRI of the lumbar spine dated 7-18-08 shows a mild broad-based disc bulge without canal or foraminal stenosis at L4-L5. There is mild facet arthropathy at L5-S1, there is a small central disc protrusion without evidence of neural impingement.

On 7-21-08, the claimant was evaluated by , MD. The evaluator reported the claimant's back pain fluctuates. Whenever he is physically active, pushing objects, pulling or lifting, the pain becomes worse. Today the pain is fluctuating between a 2 and 8. Most of the pain is on the left lower lumbar area. On exam, he is able to bend forward to the mid lower leg level. He is neurologically intact to motor and reflexes. There is some decreased sensation of the right posterior thigh. The evaluator reported that a lumbar MRI dated 07/18/08 shows desiccation of L1-2, L4-5 and L5-S1 - There is a central and right-sided L4-5 herniated disc. The evaluator recommended the claimant continue Soma and Relafen, they both help him. The evaluator reported the claimant has had the problem for a long time. The evaluator recommended a right L4-L5 transforaminal epidural injection for diagnostic, as well as therapeutic modality.

On 8-13-08, the claimant was evaluated by , MD. The claimant reported that his lumbar pain although triggered with activity or extended periods of flexing can escalate to levels of 8 on a scale of 0 to 10. The symptoms are constant and over the last several weeks have worsened considerably. He is also reporting that the bilateral lower extremity radicular pain and numbness that radiates from the gluteal region and posterior thighs has escalated on the left more so than on the right. He also states there has been some numbness occurring along the lateral aspect of the left lower leg. The evaluator noted that he received a denial for the previously requested L4-L5 transforaminal epidural injection with multiple erroneous information for the rationale of denial. On exam, the claimant stands from a sitting position in a guarded motion secondary to stiffness through the lumbar region. The lumbar spine has a guarded movement that exacerbates with extension, as well as extending from a flexed position. The lower extremities demonstrate a generalized decreased sensation along the left lateral lower leg, as well as both posterior thighs. Motor function is intact with a positive left straight leg raise test and a negative bilateral Patrick's. The deep tendon reflexes are symmetrical bilaterally. The evaluator reported that the claimant has already attempted and failed multiple forms of conservative treatment that included physical therapy. Furthermore, the use of medications only helps curb the sharper edges of the pain, but at no point has the patient had any level of comfort. The evaluator reported that in every single one of the visits, the patient has complained of radiculopathy and they were well-documented with both subjective and objective findings. There are neurological changes and physical exam. The claimant continues to suffer with symptoms as the bureaucratic hurdles keep piling up in front of him. The evaluator reported he would like to submit for reconsideration in the hopes that somebody does

actually read the information provided so they can prove this injection for this claimant with neurological changes and positive radiological findings.

On 10-1-08 , MD., performed a Utilization Report. The evaluator non-authorized the request for a lumbar transforaminal ESI x 2. The reviewer noted that the MRI did not show findings of any nerve root entrapment in the central canal or foramen.

On 11-19-08, , MD., performed a reconsideration. It was his opinion that the requested transforaminal epidural steroid injection was not reasonable or medically indicated. The evaluator noted that there was no objective diagnostic testing demonstrating pathology, which would be responsible for an active radiculopathy.

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

Medical records reflect a claimant with low back pain and radicular complaints. On exam, it is noted the claimant has generalized decreased sensation along the left lateral lower leg, as well as both posterior thighs. Motor function is intact with a positive left straight leg raise test and a negative bilateral Patrick's. According to ODG-TWC Guidelines, 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. Radiculopathy must be documented. Objective findings on examination need to be present and initially unresponsive to conservative treatment (exercises, physical methods, NSAID's and muscle relaxants). Based on the medical records provided, this claimant has non-specific radicular complaints that do not follow a dermatomal distribution. The claimant's MRI shows a mild broad-based disc bulge without canal or foraminal stenosis at L4-L5. There is no objective evidence of compressing structures to the neural canal. Therefore, the request for L4-L5 transforaminal epidural steroid injection is not evident.

ODG-TWC, last update 12-31-08 Occupational Disorders of the Lumbar Spine – Lumbar transforaminal 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](#)) ([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](#))

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, NSAID's 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

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)**