mcmc
managing care. managing claims.
88 Black Falcon Avenue, Suite 353 Boston, MA 02210 (T) 800-227-1464 (F) 617-375-7777

**DATE OF REVIEW:**
05/04/2009/Amended 05/08/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**
Bilateral lumbar epidural steroid injection transforaminal at L5/S1 under fluoroscopy; TENS unit trial; referral to psychiatrist; and referral to urologist.
**Amendment: Referral to psychiatrist and urologist not under review.**

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**
Doctor of Osteopathy, Board Certified Anesthesiologist, Specializing in Pain Management

**REVIEW OUTCOME**
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: **Upheld**

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 transforaminal epidural (TFE) at L5/S1 under fluoroscopy is not medically necessary; a TENS unit is not medically necessary.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**
- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 04/22/09 MCMC Referral
- 04/22/09 Notice to MCMC, LLC of Case Assignment, DWC
- 04/22/09 Position Statement, RN, CMS
- 04/21/09 Confirmation Of Receipt Of A Request For A Review, DWC
- 04/06/09 Workers Compensation Request For Authorization, Pain Management
- 04/03/09 Request For A Review By An Independent Review Organization, DWC
- 03/18/09 letter from RN, CMS
- 03/18/09 Progress Report, M.D., Pain Management
- 03/18/09 Appeal from M.D., Physicians
- 02/24/09 Request For Expedited Appeal, M.D., Pain Management
- 02/18/09 letter from, RN, CMS
- 02/18/09 Initial Review from M.D., Physicians
- 02/17/09 Fax Cover with note from Dr. Pain Management
- 02/17/09 Workers Compensation Request For Authorization, Pain Management
- 01/29/09 History and Physical, M.D., Pain Management
- 01/19/09 MRI/MR lumbar spine,
- 01/15/09 MRI/MR cervical spine,

88 Black Falcon Avenue, Suite 353 Boston, MA 02210 (T) 800-227-1464 (F) 617-375-7777

- 10/30/08 Neurosurgery Consultation, M.D.,
- 10/29/08 Neurosurgical Consultation, M.D.,
- 10/29/08 Emergency Room Report, M.D.,
- Note: Carrier did not supply ODG Guidelines.

**PATIENT CLINICAL HISTORY [SUMMARY]:**
The injured individual is a male with date of injury xx-xx-xx. The injured individual had epidural steroid injections (ESIs) that failed multiple times. He then had a L2/3 discectomy that left him with left foot drop. He had psychotherapy and biofeedback. He had his last ESI in 10/2008 and ended up in the hospital a few days later due to increased pain. He had emergency lumbar surgery and was left with left foot drop. He saw his pain physician in 01/2009 and he noted past ESIs had helped but the Independent Medical Exam (IME) report stated they failed since 2004 and had been done by different physicians. He has no genitourinary (GU) complaints at all until 2009 when the pain physician states he has difficulty urinating and requests a GU consult. He also asked for a psychiatric consult to help with medication management due to his bipolar disorder and drug addiction.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**
The ESI is denied as the injured individual had one in 10/2008 with major pain after and ended up as an inpatient in the hospital. He had ESIs before this with minimal to no benefit as well. It is not reasonable to repeat a failed procedure.

The TENS unit is denied as the injured individual has chronic back pain, is not doing any type of home exercise program (HEP to help maintain function, and the overall efficacy of a TENS is highly questionable.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**
**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
Official Disability Guidelines for ESI: 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. (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

88 Black Falcon Avenue, Suite 353 Boston, MA 02210 (T) 800-227-1464 (F) 617-375-7777

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) (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.)

Official Disability Guidelines for TENS: Not recommended as an isolated intervention, but a one-month home-based TENS trial may be considered as a noninvasive conservative option for chronic back pain, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration, including reductions in medication use.
Acute: Not recommended based on published literature and a consensus of current guidelines. No proven efficacy has been shown for the treatment of acute low back symptoms. (1994) (1999) (2006)
Chronic: Not generally recommended as there is strong evidence that TENS is not more effective than placebo or sham. (2006) There is minimal data on how efficacy is affected by type of application, site of application, treatment duration, and optimal frequency/intensity. (2002) There are sparse randomized controlled trials that have investigated TENS for low back pain. One study of 30 subjects showed a significant decrease in pain intensity over a 60-minute treatment period and for 60 minutes after. (1999) A larger trial of 145 subjects showed no difference between placebo and TENS treatment. (1990) Single-dose studies may not be effective for evaluating long-term outcomes, or the standard type of use of this modality in a clinical setting. (2001) (2001) (2001) (2001) (2004) (2002) (2005) (2, 2005) Although electrotherapeutic modalities are frequently used in the management of CLBP, few studies were found to support their use. Most studies on TENS can be considered of relatively poor methodological quality. TENS does not appear to have an impact on perceived disability or long-term pain. High frequency TENS appears to be more effective on pain intensity when compared with low frequency, but this has to be confirmed in future comparative trials. It is also not known if adding TENS to an evidence-based intervention, such as exercise, improves even more outcomes, but studies assessing the interactions between exercise and TENS found no cumulative impact. (2008) For more information, see the Pain Chapter.
Recent research: A recent meta-analysis concluded that the evidence from the small number of placebo-controlled trials does not support the use of TENS in the routine management of chronic

88 Black Falcon Avenue, Suite 353 Boston, MA 02210 (T) 800-227-1464 (F) 617-375-7777

LBP. There was conflicting evidence about whether TENS was beneficial in reducing back pain intensity and consistent evidence that it did not improve back-specific functional status. There was moderate evidence that work status and the use of medical services did not change with treatment. Patients treated with acupuncture-like TENS responded similarly to those treated with conventional TENS. (2008)