

# P&S Network, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 10/13/09

**IRO CASE #:**

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

This case was reviewed by a Pain Management (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Injection, anesthetic agent and/or steroid transforaminal epidural; lumbar or sacral, single level, DOS: from 8/25/09 to 08/25/09.

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 03-30-05 Lumbar myelogram/CT scan read by Dr.
- o 09-19-05 MRI report, lumbar, read by Dr.
- o 04-07-06 Functional Capacity Evaluation from , PT.
- o 09-05-06 Follow-up report from Dr.
- o 01-04-07 Follow-up report from Dr.
- o 05-03-07 Follow-up report from Dr.
- o 08-30-07 Follow-up report from Dr.
- o 12-26-07 Follow-up report from Dr.
- o 04-23-08 Follow-up report from Dr.
- o 08-22-08 Follow-up report from Dr.
- o 12-19-08 Follow-up report from Dr.
- o 06-17-09 Follow-up report from Dr.
- o 06-29-09 Radiology report read by Dr.
- o 07-01-09 Follow-up report from Dr.
- o 07-20-09 Consultation report from Dr.
- o 08-27-09 Non-certification letter
- o 09-02-09 Non-certification for reconsideration
- o 09-24-09 Request for IRO from the Claimant

- o 09-25-09 Confirmation of Receipt of IRO from TDI
- o 09-28-09 Notification of Case Assignment from TDI.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records and prior reviews the patient is a male who sustained an industrial injury to the low back on xx/xx/xx. He is status post bilateral L4-5 foraminotomies and laminotomies secondary to stenosis and disc disease and is followed for continuing low back and left lower extremity pain.

Lumbar myelogram of March 2005 revealed moderately severe central stenosis at L4-5 secondary to broad-based non-lateralizing disc protrusion/herniation in combination with bilateral facet ligamentous hypertrophy. Post-myelogram CT scan revealed: 1.

Broad-based disc protrusion L4-5 with slight lateralization left. Facet and ligamentous hypertrophic changes are also present. 2. Degree of central canal stenosis at L4-5 appears less significant on the supine recumbent images than it did in the upright weight bearing myelogram images.

Lumbar MRI performed September 2005 revealed findings of underlying congenital (primary) spinal canal stenosis throughout the lumbar spine. At L4-5, there is a left laminotomy with removal of the previous left paracentral disc protrusion. There is no significant spinal canal stenosis. The remainder of the lumbar spine is within normal limits.

The patient underwent an FCE on April 2, 2006. His employment requires medium physical demand with very occasional heavy demand (50-125 pounds). He is currently functioning at a light PDL (30 pounds) which is inadequate for his job requirements. A recommendation was made for back school and/or PT.

The patient was seen in follow-up on September 5, 2006 and noted to be significantly symptomatic despite a lumbar surgery for his injury. He has attempted a variety of conservative treatments. Additional surgery is considered. On examination, he is neurologically intact. He is 5' 10" and 225 pounds.

The patient was seen next on January 4, 2007. He reports persisting significant back pain and no real relief from the surgery. He is only able to work part-time and is struggling to keep his family farm going. The neurologic exam is normal. Recommendation is for MRI and continue Norco.

The medical report of May 3, 2007 notes the patient continues with intractable back pain. An MRI has been ordered. On August 30, 2007 the provider notes medication is being limited by the carrier to 120 Norco (24 days worth) at a time while the patient needs 150 Norco at a time. On December 26, 2007 the provider noted repeated requests for CT/MRI have not been authorized. Reflexes are symmetric. There is no weakness in the lower extremities. Straight leg raise is positive on the left.

The medical report of April 23, 2008 notes the patient is unchanged. He is supposedly getting an ombudsman to help him navigate the work comp system. On August 22, 2008 the patient is unchanged. He reports a pain level of 5-6/10 with medication and 7-8/10 without medication. He continues to use Norco 6 times daily. On December 19, 2009 the patient is unchanged although he reports increase of Norco by one pill daily has allowed for some improvement in function.

The patient was reevaluated on June 17, 2009. He continues to have significant pain in the low back area with pain radiating onto his left leg. He has intermittent swelling to the back. An MRI has never been performed. A spinal cord stimulator has been a consideration. This also was never done. The patient continues to work but finds it rather difficult because of the increasing amount of pain. He uses 7 Norco daily and reports a pain level of 6/10. He is given a 6-month prescription for Norco. MRI is again requested.

Lumbar MRI was performed on June 29, 2009 and provided impression: Borderline central spine stenosis in the lumbar spine due to congenitally short pedicles. The AP diameter is 10 mm throughout most of the lumbar spine. Previous left L4-5 hemilaminectomy. Enhancing granulation tissue in the left ventral epidural space at L4-5 with a 1 mm central focus of non enhancement consistent with a small 1 mm recurrent disc. There is moderate left and mild-moderate right foraminal stenosis at the L4-5 due to moderate degenerative facet disease. Alignment is normal.

After reviewing the MRI results on July 1, 2009 the amended diagnosis is chronic low back pain status post work injury and surgery with increasing back pain and left leg pain with recurrent small disc herniation and enhancing granulation tissue at the L4-5 level which is the previous operative site. Recommendation is for a consultation to consider spinal cord stimulation and/or a surgical consult.

The patient was provided a consultation to consider spinal cord stimulation versus a surgical procedure on July 20, 2009. He reports back pain is greater than leg pain and his back pain radiates superiorly into his upper back and down into his left arm. He reports weakness in the left leg. He reports his entire left sided body is involved. He is using 6 Norco daily. He is currently self-employed. Gait is slightly antalgic. Motor strength is normal. Reflexes are normal. Seated straight leg is negative. There is tenderness over the facet joints about L4-5 and extension increases his pain. MRI films show granulation tissue at L4-5 with patent nerve root exits. The facet joints at L4-5 are significantly hypertrophied. He appears to have postlaminectomy syndrome on the left at L4-5 as well as facet disease. Recommendation is for diagnostic medial branch blocks (to assess the facet components). Following that he should have an L4-5 transforaminal epidural injection to clarify a discogenic component to his pain. [Per a handwritten note, medial branch blocks were not certified per ODG.]

Request for transforaminal epidural steroid injection lumbar or sacral was considered in review on August 27, 2009 and recommended for non-certification with rationale that there was no documentation that rehabilitation was taking place and the objective physical examination findings have not documented radicular pain in a dermatomal pattern. There are no objective

findings of radiculopathy.

Request for appeal transforaminal epidural steroid injection L4-5 was not certified in review on September 2, 2009 with rationale that the patient has no documented objective radicular symptoms and has basically a normal physical examination except for tenderness at the facet joints.

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

The patient has chronic low back pain with left leg symptoms despite a decompression surgery at L4-5 in 2005. He is managed medically with Norco with quarterly reevaluations. He reports worsening symptoms that eventually include his upper back and arm. He reports some left leg weakness.

Updated MRI of June 2009 reveals, borderline central spine stenosis in the lumbar spine due to (pre-existing) congenitally short pedicles, a previous left L4-5 hemilaminectomy, granulation tissue in the left ventral epidural space at L4-5 with a 1 mm central focus of non enhancement consistent with a small 1 mm recurrent disc, and a moderate left and mild- moderate right foramina stenosis at the L4-5 due to moderate degeneration facet disease. Nerve studies have not been reported to clarify any radiculopathy.

Clinically, gait is slightly antalgic, motor strength is normal, reflexes are normal, seated straight leg is negative and there is tenderness over the facet joints about L4-5 and extension increases his pain. He has indications of facet mediated pain. However, median branch block has reportedly not been authorized. Per examination findings, there is no objective indication of radiculopathy.

Per ODG, the following criteria for epidural injections has not been met: (1) Radiculopathy must be documented. Objective findings on examination need to be present. (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

While it is noted that the FCE recommendations of 2006 included, participation in back school and/or PT, given that the clinical findings do not establish radiculopathy and there does not appear to be active rehabilitation in process, my recommendation is to agree with the previous non-certification of the request for Injection, anesthetic agent and/or steroid transforaminal epidural; lumbar or sacral, single level, DOS: from 8/25/09 to 08/25/09.

The IRO's decision is consistent with the following guidelines:

**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

X  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

The Official Disability Guidelines, Low Back Chapter (9-29-2009) 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) 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.

Fluoroscopic guidance: Fluoroscopic guidance with use of contrast is recommended for all approaches as needle misplacement may be a cause of treatment failure.

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. 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.

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. Recent studies document a 629% increase in expenditures for ESIs, without demonstrated improvements in patient outcomes or disability rates. There is fair evidence that epidural steroid injection is moderately effective for short-term (but not long-term) symptom relief.

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.)