

# P&S Network, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 10/22/09

**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, single (not via indwelling catheter) not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (in dates of service from 09/28/09 to 10/28/09 (lumbar epidural steroid injection).

**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 07-02-01 Consultation Evaluation notes from Dr.
- o 07-02-01 Initial Consultation report from Dr.
- o 09-07-05 Operative Report from Dr.
- o 01-12-06 Follow-up Examination from Dr.
- o 03-14-06 Follow-up Examination from Dr.
- o 05-02-06 Follow-up Examination from Dr.
- o 04-09-06 Follow-up Examination from Dr.
- o 07-11-06 Follow-up Examination from Dr.
- o 08-15-06 Follow-up Examination from Dr.
- o 10-17-06 Follow-up Examination from Dr.
- o 01-02-07 Follow-up Examination from Dr.
- o 02-06-07 Follow-up Examination from Dr.
- o 03-20-07 Follow-up Examination from Dr.
- o 05-01-09 Follow-up Examination from Dr.
- o 06-07-09 Follow-up Examination from Dr.
- o 11-27-07 Follow-up Examination from Dr.
- o 02-07-08 Follow-up Examination from Dr.
- o 03-06-08 Follow-up Examination from Dr.
- o 04-15-08 Follow-up Examination from Dr.
- o 05-20-08 Follow-up Examination from Dr.
- o 07-31-08 Follow-up Examination from Dr.
- o 09-16-09 Follow-up Examination from Dr.
- o 12-09-08 Follow-up Examination from Dr.
- o 01-23-09 Follow-up Examination from Dr.
- o 04-28-09 Follow-up Examination from Dr.

- o 05-19-09 Follow-up Examination from Dr.
- o 05-26-09 Follow-up Examination from Dr.
- o 06-23-09 Follow-up Examination from Dr.
- o 09-08-09 Medical report from Dr.
- o 09-17-09 Physician Review Recommendation, non-cert LESI,
- o 09-18-09 Letter of non-certification for LESI
- o 09-25-09 Request for approval of LESI letter from Dr.
- o 09-30-09 Physician Review recommendation for reconsideration LESI
- o 09-30-09 Letter of non-determination for LESI
- o 10-05-09 Confirmation of Receipt of IRO from TDI
- o 10-05-09 Request for IRO from claimant
- o 10-05-09 Notice of Case Assignment from TDI

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

According to the medical records and prior reviews the patient is an employee who sustained an injury to the low back on xx/xx/xx.. She initially was provided medication and PT and subsequently returned to modified duties. An MRI performed in May 2001 was interpreted as negative. SI joint injections and trigger point injections were provided. The patient is described as 4' 11" and 142 pounds. She smokes one pack of cigarettes daily (per 2002 report). Her symptoms persisted and she underwent lumbar laminectomy with a fusion in 2005 for low back pain with numbness into the right leg. The current diagnosis is low back and lower extremity pain, herniated disc and failed back syndrome. She is being followed with pain management.

The medical report of January 2006 notes the patient is ambulating with a cane and using Duragesic patches for mild to moderate pain. Trigger point injections were provided. Clonidine 0.2 mg every 7 days was initiated. On April 9, 2006 the patient initiated Lyrica 75 mg twice daily for myofascial and neuropathic pain to the lower back. Medications include Duragesic patch, Flexeril, Hydrocodone and Lyrica.

The medical report of July 11, 2006 indicates the patient will be provided a series of 2 lumbar epidural injections for failed back syndrome with radiculopathy, exacerbated. Lyrica was not authorized in August 2006.

On January 2, 2007 Toradol 60 mg injection is provided for a flare-up. The report of February 6, 2007 indicates medications and treatment are being denied based on IME opinions. On March 20, 2007 a Toradol injection is provided. The patient has attended a rehabilitation program. A Toradol injection was provided on May 1, 2007.

The patient was seen on February 7, 2008 for increased pain secondary to a medical examination. Her prescriptions are being delayed. A Toradol injection is provided. On March 6, 2009 a Toradol injection was provided for increased pain. On April 15, 2008 a Toradol injection was provided for exacerbation of pain. On May 20, 2008 the patient was considering the possibility of returning to work on a part-time basis.

The medical report of July 31, 2008 indicates the patient has been using a spinal cord stimulator which is functioning appropriately. A Toradol injection was provided. On December 9, 2008 a Toradol injection was provided.

The medical report of January 13, 2009 notes the same and repeated examination of prior reports: She has specific areas of active and reproducible trigger point tenderness noted to the quadratus lumborum, the gluteus maximus and the gluteus medius. There is limited range of motion of the lumbar spine secondary to pain. A Toradol injection 60 mg was provided. The medical report of April 28, 2009 is essentially identical; a Toradol injection is provided.

On May 19, 2009 the patient reported an acute exacerbation and was unable to stand upright. The exam is unchanged. A trigger point injection with Toradol was provided and an injection of Kenalog for pain. If she does not improve, lumbar epidural steroid injection will be recommended. The patient returned on May 26, 2009 reporting severe pain not relieved with a Toradol injection. Her posture is very flexed. She has difficulty moving about. She notes pain radiating down both legs with numbness and tingling past the knees. Recommendation is for a lumbar epidural steroid injection.

The patient was reevaluated on June 23, 2009 for persisting exacerbation of her back pain with radiation and numbness and tingling into both legs. Her gait is guarded and her posture very forward flexed. Assessment is low back and lower extremity pain, herniated disc and failed back syndrome. A request for lumbar epidural was not authorized by the carrier. The patient was encouraged to be as active as possible.

The patient returned on September 8, 2009. She reports persisting moderate to severe pain. She has taken up to 10 of the gabapentin 600 mg and up to 10 of the Vicodin 7.5/500 mg daily. She has been treated with medication and a home exercise program. She is status post laminectomy with fusion in 2005. The objective findings are the same as the prior report. A Toradol injection was provided. The patient will, reportedly, continue a daily exercise program.

Request for lumbar epidural steroid injection, levels not indicated, was considered in review on September 17, 2009 and

recommendation made for non-certification. An imaging report was not submitted. The physical examination did not document radiculopathy, sensory changes or motor deficits as required by ODG to warrant the requested intervention. A peer discussion was attempted but not realized.

The provider requested reconsideration on September 25, 2009. The 11 ODG criteria for these injections are noted with notes attached as to how the patient meets each criteria. Per the provider, radiculopathy is documented by the patient's subjective report of pain radiating down both legs with a burning and shooting pain to the feet and positive straight leg raise bilaterally at 45 degrees. The patient has failed conservative treatments including NSAIDs, pain medications, muscle relaxers and has had PT in the past. She uses a heating pad and showers at home for relief.

Request for appeal lumbar epidural steroid injection was considered in review on September 30, 2009 with recommendation given for non-certification. The patient may have had prior ESIs but this was not clarified as to frequency and benefit. The most recent examination did not document sensory, motor or deep tendon reflex findings. In this patient, there was no documentation of radicular findings on the physical examination, but the appeal stated the patient had a positive straight leg raise (SLR). There were no imaging studies provided for review. Based on lack of documentation, the request was not considered medically necessary. A peer discussion was attempted but not realized.

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

Despite a normal MRI and a history of heavy smoking, the patient underwent lumbar laminectomy with a fusion in 2005 for low back pain with numbness into the right leg which resulted in post-laminectomy syndrome. In 2006 medications were noted as Duragesic patch, Flexeril, Hydrocodone and Lyrica. The patient has been seen in pain management with primary treatment of Toradol injections at varying intervals.

The medical report of July 31, 2008 indicates the patient has been using a spinal cord stimulator which is functioning appropriately. Curiously this treatment is not mentioned elsewhere in the reviewed records. The patient has been experiencing increased symptoms since May 2008. At some point in the past the patient attended rehabilitation and was instructed in home exercises. Compliance with Independent exercises is not clarified. The most recent appeal letter states, she uses a heating pad and showers at home for relief. Clearly the patient is not involved in an active physical rehabilitation program, either formally or independently. Additionally, per ODG, radiculopathy must be documented; objective findings on examination need to be present. A thorough physical examination is not found in almost four years duration of follow-up progress reports. The objective examination findings do not include a motor or sensation deficit to corroborate subjective reports of lower extremity symptoms. Radiculopathy in a dermatomal pattern is not documented. Documentation of straight leg raise is also not found in the reviewed reports. The level desired for injection is not clarified.

Per ODG, chronic duration of symptoms (> 6 months) has been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months. The patient is over 8 years post injury and approximately 4 years post lumbar surgery. ODG also states, 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. The patient is status post lumbar fusion. The patient's current smoking status is not clarified.

Overall, the clinical findings do not establish a medical necessity for epidural injection per ODG criteria. Therefore, recommendation is to agree with the previous non-certification of the request for lumbar epidural steroid injection, level not indicated.

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 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

The Official Disability Guidelines - Low Back Chapter (10-2-2009) 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. 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. 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.

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. 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. 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. 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. 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).

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.)