CLAIMS EVAL

Utilization Review and
Peer Review Services

Notice of Independent Review Decision-WC

DATE OF REVIEW: 3-18-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

One lumbar epidural steroid injection at L5-S1 level under fluoroscopic guidance between 1/27/2010 and 3/28/2010.

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

- 3-14-05 MRI of the lumbar spine.
- 6-2-05 NCS and SSEP performed by, MD.
- 7-26-05 MD, office visit.
- 10-11-05 Surgery performed by MD.
- 5-11-07 MRI of the lumbar spine.
- PAC., office visits on 12-5-05, 1-23-06, 3-8-06, 7-13-06, 4-19-07, 5-17-07, 1-10-08, 4-8-08, 2-3-09 3-3-09, 3-31-09, 7-6-09, 10-5-09, 1-20-10, and 2-10-10.
- 1-12-09, DC, office visit.
- 2-3-09 X-rays of the lumbar spine.
- 2-16-09 Physical therapy.
- 2-20-09 MRI of the lumbar spine.
- 3-2-09 MD., performed a Peer Review.
- 1-26-10 DO., performed a Utilization Review.
- 2-2-10 MD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

MRI of the lumbar spine shows an 8 mm right paracentral extrusion at L5-S1 extends slightly above the disc level. The extrusion compresses and displaces the right S1 nerve root posterolaterally. Correlation with right S1 radiculopathy is suggested. There is no central foraminal stenosis in the lumbar spine.

A NCS performed by MD., dated 6-2-05 shows bilateral L4-L5 and L5-S1 radiculopathy. SSEP showed left L4, bilateral L5-S1 radiculopathy.

On 7-26-05, the claimant was evaluated by MD. It was noted the claimant continued to work at a fairly heavy level. The claimant has pain and gets occasional radicular pain. The evaluator reported that the claimant had a fairly large herniation at L5-S1 and in his opinion, the claimant should have surgery.

On 10-11-05, the claimant underwent discectomy at right L5-S1 performed by MD.

MRI of the lumbar spine dated 5-11-07 shows status post small right sided laminectomy at L5-S1. 7 mm ventral defect at L5-S1 causing some mass effect on the anterior thecal sac with contact of the S1 nerve root sleeves with the right side more involved than the left. There is evidence of enhancement within this ventral defect. The findings are suspicious for a broad based disc extrusion with annular fissure and/or scar based on the gree of mass effect. However, some enhancing granulation tissue accounting fro some of these changes cannot be excluded. Disc desiccation and minimal disc loss at the L5-S1 level. Small posterior osteophytes are also visualized.

Medical records reflect the claimant continued to follow up at Back Institute under the care of Dr. PAC. The claimant was provided treatment with medications and physical therapy.

The claimant sought medical attention under the direction of, DC, on 1-12-09. The claimant stated that he was experiencing lower back symptoms of an achy and burning nature. There was radiation of the symptoms from the lower back to the buttocks. This also causes his legs to feel cold and his toes to feel numb at times. He also reports that his left leg gives out on him at time. Mr. was involved in a work related accident on xx/xx/xx. Currently, he is working regular duty. The primary diagnosis is lumbar neuritis with lumbar disc displacement and muscle pain/myalgia. The claimant is currently under long term care for a chronic condition and the overall prognosis is fair. The treatment schedule will be a visit PRN. The purpose of care is to reduce his pain, increase his ranges of motion and increase his overall flexibility. Due to the continued objective and subjective findings, the evaluator referred the claimant to Back institute for a follow-up evaluation and treatment.

X-rays of the lumbar spine dated 2-3-09 interpreted by PAC., shows on AP view of his lumbar spine, he has 5 mobile lumbar segments. SI joints appear to be unremarkable. On lateral view, he does not demonstrate any signs of instability with forward flexion or extension. He has moderately degenerative disk at L5-S1; all other disk levels appeared to be within normal limits. He does not demonstrate any neoplastic changes.

The claimant was provided with physical therapy on 2-16-09.

MRI of the lumbar spine on 2-20-09 shows large disc extrusion at L5-S1 compressing the traversing S1 nerve roots bilaterally.

On 3-2-09, MD., performed a Peer Review. It was his opinion that the final diagnosis per orthopedic spine surgeon is status post laminectomy/discectomy L5- S1 with

intermittent low back and left lower extremity pain currently asymptomatic, status post bilateral inguinal herniorrhaphy at present asymptomatic. As for office visits, diagnostics, procedures and modalities, the reviewer saw no deviations from the guidelines. Therefore, care has been reasonable. The orthopedic spine surgeon however does request that the claimant follow up on an as needed basis should he have any recurrence of the lower back or lower extremity symptoms. The reviewer noted that in his opinion, this is a reasonable request. At present the last medication prescribed on the occasion of the claimant's current strain of his groin appears to be a short term analgesic prescription, and he does not appear to be on any medications for that diagnosis. For the diagnosis of his lower back, no prescriptions are discussed at the last follow up. The last references to possible repeat surgery would be for recurrent symptoms primarily neurologic from the recurrent disc herniation diagnosed by MRI. Should the claimant again become symptomatic and not respond to non operative treatment as suggested by Dr. prior recommendations, repeat surgical consultation would be considered reasonable required.

Follow up with PAC., on 10-5-09 notes the claimant has been doing quite well because he had been off work. The evaluator recommended the claimant use over the counter anti-inflammatories. The claimant was also provided some Zanaflex.

On 1-20-10, the claimant was evaluated by PAC., has had a severe increase in some left buttock pain as well as left leg pain. He notes that it actually began on Friday and has progressively worsened over the weekend in the past couple of days. He states his leg has been aching for approximately 2 months but now it has become very severe and he is even having difficulty sleeping because of the pain. He does feel some weakness in that leg as well. He denies any bowel or bladder dysfunction at this time. On exam, he does have an antalgic gait. Patellar reflexes are 2+ and symmetric. Achilles reflexes are 1+ and symmetric. Manual motor testing shows 4+/5 weakness in the left planter flexor. All else is 5/5. SLR on the right is negative and at the left approximately 40 degrees produces pain radiating down the leg. The evaluator recommended Medrol Dosepak. The evaluator also suggested a lumbar epidural steroid injection.

On 1-26-10 DO., performed a Utilization Review. It was her opinion that Claimant has had increasing left buttock and left pain over last 2 months and has become severe. There are exam findings and MRI corroboration of left Si radiculopathy. However, there is no evidence that conservative treatments such as medications and PT have failed for this relatively new symptom and finding. In addition, since exam findings are only left sided, medical reasoning for bilateral ESI was not documented.

On 2-2-10 MD., performed a Utilization Review. It was his opinion that In the latest record submitted, dated 1-20-10, the claimant presents with worsening left buttock and left leg pain associated with weakness. Physical examination findings reveal a +1 symmetric Achilles reflexes, and 4/5 weakness in his left plantar flexor. The provider is requesting for a lumbar Epidural Spinal Injection under fluoroscopy. However, Epidural Steroid Injections are indicated in the presence of radiculopathy as corroborated by electrodiagnostic and/or imaging studies aside from the positive examination findings.

There is none in the records that supports this. There is no documentation provided with regards to the failure of the claimant to respond to conservative measures such as evidence-based exercise program and medications prior to the proposed injections. No therapy progress reports were submitted for review to validate that the claimant has had sufficient number of therapy as well as optimized pharmacological treatment, as well as the claimant's failure to respond to treatment. Furthermore, the presence of a previous back surgery and the chronicity of this back pain are negative factors to the success of this injection. At this point in time, the medical necessity of this request is not fully established.

2-10-10 PAC., the claimant has not undergone his lumbar epidural steroid injection at the L5-S1 level secondary to a denial by Worker's Compensation. They felt that he continues to have lower back pain as well as leg pain which are significantly worse in the left. He did have an MRI performed in February 2009 that demonstrated a large disk extrusion at the L5- S1 level that is bilaterally contacting the Si nerve roots. He obviously shows signs of radiculopathy that correlate with the MRI finding from last year. He was placed on a Medrol Dosepak without very much relief. He has been taking Hydrocodone with some minimal relief and he continues to have difficulty with sleeping secondary to the amount of pain that he is in. He does continue to work, however, and it is becoming more and more difficult for him to do so. He denies any bowel or bladder dysfunction at this time. He has been through physical therapy in the past without very much relief. On physical exam, the claimant is a gentleman. He is alert and oriented x3 with a regular respiratory rate of 16. He is able to ambulate without assistance. However, he does have an antalgic gait Patellar reflexes are 2+ and symmetric. Achilles reflex is 2+ on the right, a 1+ on the left. He demonstrates weakness in his gastrocnemius of a 4/5 on the left and a 5-/5 on the right. All else is a 5/5. Seated straight leg raise on the right is negative, on the left at approximately 60 degrees produces pain radiated down his left leg. Impression: Herniated nucleus pulposus at L5-S 1 with corresponding radiculopathy which was seen MRI dated February 2009 as well as with a corresponding physical examination. Plan: The claimant has been placed on a Medrol Dosepak, he failed that. He has been placed on Hydrocodone with only minimal relief. He is having difficulty with sleeping. Therefore, the evaluator placed him on a sleep aid secondary to the amount of pain that he is in. He has continued to work throughout all of this difficulty but continues to have persistent pain in her left lower extremity. Therefore based on his physical exam as well as the findings of his MRI from February 2009, the evaluator believed he is a perfect candidate for an epidural steroid injection.

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

BASED ON THE MEDICAL RECORDS PROVIDED, IT IS MY OPINION THAT IT IS REASONABLE TO PERFORM THE L5-S1 EPIDURAL STEROID INJECTION DIRECTED TO THE LEFT. THE CLAIMANT HAS FAILED CONSERVATIVE

THERAPY. THE CLAIMANT HAD BEEN WORKING AND APPEARED TO HAVE BEEN ACTIVE. PHYSICAL THERAPY IN THE PAST DID NOT PROVIDE BENEFIT. ORAL MEDICATIONS WERE NOT OF BENEFIT. THEREFORE, THE EPIDURAL STEROID INJECTION IS NECESSARY AND APPROPRIATE FOR THIS CLAIMANT.

ODG-TWC, last update 3-17-10 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) (Delport, 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. (Deyo, 2009) There is fair evidence that epidural steroid injection is moderately effective for short-term (but not long-term) symptom relief. (Chou3, 2009) This RCT concluded that caudal epidural injections containing steroids demonstrated better and faster efficacy than placebo. (Sayegh, 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 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)**