



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WCN

CLAIMS EVAL REVIEWER REPORT - WCN

DATE OF REVIEW: 12-28-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Second left L4-L5 lumbar epidural steroid injection

(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).)

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

- 8-28-09 MD., office visit.
- 10-8-09 Translaminar L4-L5 injection performed by Dr.
- 10-28-09 , MD., office visit.
- 11-4-09 DO., performed a Utilization Review.
- 11-13-09 MD., performed a utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Office visit with MD., on 8-28-09 notes the claimant is male who is referred by M.D. for epidural steroid injection to try to relieve severe low back and left leg pain secondary to disc herniation and foraminal encroachment at L4-5. The patient has had a long history of back problems going back into the early 90s and underwent microdiscectomy in 1990 by Dr. which really helped him a lot and he has been free of low back ever since. In 2005, he was working at UPS and sustained an injury while lifting up heavy objects and responded well to conservative therapy. On 6-29-09, he was lifting some bags and experienced severe low back pain and the next day started getting severe radiating type radicular pain down his left leg, which has gotten a lot worse. The patient states the pain in his low back is aching type pain. He is getting numbness, tingling, and definite weakness in the muscles of his left leg. An MRI has been done previously on the patient and the MRI was evaluated by myself and there definitely appears to be at L4-L5 a broad-based disc protrusion, which combined with some facet arthropathy is causing bilateral foraminal encroachment that in my opinion the left is worse than the right. At L4-L5, there is also evidence of an annular tear but the foramina really do not appear to be overly involved at this level. The central canal is patent. The patient states he is doing light duty at UPS. He has not done well with physical therapy and takes occasional NSAIDs for his pain as prescribed by Dr. The evaluator reviewed Dr. records and the patient's description fits closely with Dr. evaluations. The claimant has been referred to this facility for epidural injections to try to decrease the inflammatory response around the nerve roots and allow the patient to get back to doing his full duty at UPS. The patient states he has not done physical therapy in quite some time, as he just did not really respond to this. Dr. referral from US HealthWorks reflects request for the epidural injection. His MRI was done in 2008 and has not been repeated and there is probable reason to believe the conditions at L5-S1 and L4-L5 have probably deteriorated. On exam, the gait is minimally antalgic with predominant weightbearing on the left leg. The patient holds his hip slightly flexed and the knee slightly flexed. There appears to be some moderate wasting on the calf muscles on the left. Examination of the lumbar spine shows significant decreased range of motion in all planes. The normal lumbar lordosis is completely flattened. There is moderate to severe muscle spasm in the lower back long extensors but no trigger point or taut band activity. Range of motion testing is guarded with pain elicited at about 5 degrees with left lateral flexion and rotation. Extension is not more than about 5 degrees and flexion about 35-45 degrees. Waddell signs are 0/5. Facets provocative maneuvers are negative.

Straight leg raising test is strongly positive on the left at about 15 degrees in the supine position. Crossed straight leg raising test is negative. Motor strength testing in the lower extremities shows definite L4 and L5 weakness about a -5/5 in the quadriceps and hamstrings as well as the calf muscles on the left. Deep tendon reflexes are 2+ patellar and Achilles tendon on the right. The left is -1 patellar and -2 Achilles tendon on the left. There is no ankle clonus. Babinski is negative. Detailed sensory testing to light touch shows definite L5 deficit on the right side. Interestingly the extensor hallucis longus on the left is 5/5 and the same is on the right. The evaluator felt the claimant had a broad-based disc herniation L4-L5 with L4 probable L5 radiculopathy on the left side. Dr. recommended a lumbar epidural steroid injection at L4-L5 with bias to the left.

On 10-8-09, the claimant was provided a translaminar L4-L5 injection with bias to the left.

On 10-28-09, the claimant was evaluated by, MD. The claimant states that the epidural steroid injection improved his back pain but his left leg pain is still severe. He is also experiencing increasing numbness along the distribution of L4-L5. He is experiencing some weakness and loss of sensation as well in those dermatomes. The claimant has also taken off from work because of the weakness in his leg and wondering where to go from here. On exam, the claimant has significant decrease in patellar jerk on the left also definite dermatomal deficits of L4 and L5 on the left and weakness of EHL on the left as compared to the right. SLR is 20 degrees. Achilles tendon jerks are 2+ bilaterally. There is no muscle wasting. The claimant's gait is minimally antalgic but he does predominantly weight bear on the right leg. There is no sciatic notch tenderness. The evaluator requested authorization to repeat the epidural steroid injection at L4-L5 with bias to the left. The evaluator also requested an evaluation for a chronic pain program. The claimant was provided a prescription for Robaxin and Ultracet. The evaluator also requested apt evaluation.

On 11-4-09, DO., performed a Utilization Review. The evaluator reported the claimant has left leg radicular findings on physical exam. However, he has had questionable response to the first epidural steroid injection since there are no pain scores to gauge it by nor percentage of relief or duration documented. Therefore, since it apparently did not even help his leg pain, a second epidural steroid injection is not indicated.

11-13-09, MD., performed a utilization Review. The evaluator reported that the request is for a second left L4-L5 lumbar epidural steroid injection. The evaluator reported it is not medically necessary. According to the submitted medical record, the claimant does not appear to satisfy the criteria for a second lumbar epidural steroid injection according to ODG Treatment index. In particular, there does not seem to be an adequate response to the first epidural steroid injection to justify a second diagnostic epidural steroid injection. Although occasionally a second epidural steroid injection will provide better results than the first, this is distinctly uncommon.

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

Based on the medical records provided, I am in agreement with the first two reviewers. The claimant did not appear to have a favorable response to the first lumbar epidural steroid injection which appeared to be performed properly. The second lumbar epidural steroid injection does not meet the criteria according to ODG Treatment guidelines. According to ODG, repeated epidural steroid injection is appropriate 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. Therefore, based on the medical records provided, the request for a second epidural steroid injection is not reasonable or medically necessary.

ODG-TWC, last update 12-18-09 Occupational Disorders of the Low Back – lumbar 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) (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) (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)

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)