

P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

Notice of Independent Review Decision

DATE OF REVIEW: 12/21/2009

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

Lumbar transforaminal ESI injection with selective nerve root block right L5-S1

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 04-16-09 Thoracic MRI read by Dr.
- o 05-01-09 PT Scripts from Dr.
- o 05-05-09 PT evaluation report from PT-
- o 05-12-09 PT Progress Note, unsigned
- o 05-14-09 PT Progress Note
- o 05-15-09 PT Progress Note from PT
- o 05-18-09 PT Progress Note from PT
- o 05-20-09 PT Progress Note from PT
- o 05-21-09 PT Progress Note from PT
- o 05-27-09 PT Progress Note from PT
- o 05-28-09 PT Progress Note from PT
- o 06-01-09 PT Progress Note from PT
- o 06-04-09 PT Progress Note from PT
- o 06-09-09 PT Progress Note from PT
- o 06-11-09 PT Progress Note
- o 06-11-09 PT Discharge Summary
- o 07-13-09 Consultation report from Dr.
- o 07-13-09 PT script from Dr.
- o 07-16-09 PT lumbar reevaluation from PT-
- o 08-18-09 Lumbar MRI read by Dr.
- o 09-04-09 Progress note from Dr.
- o 09-23-09 Phone note from Dr.
- o 10-07-09 Progress report from Dr.
- o 10-09-09 Medical report from Dr.

- o 11-09-09 Initial Adverse Determination Letter
- o 11-23-09 Reconsideration - Adverse Determination Letter
- o 11-26-09 Request for IRO from the provider
- o 12-02-09 Confirmation of receipt of Request for IRO from TDI
- o 12-03-09 Notice of Case Assignment of IRO 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 thoracolumbar spine on xx/xx/xx. He was kneeling over trying to remove a kingpin from a trailer when struck from behind by a vehicle driven by a co-worker.

Thoracic MRI of xx/xx/xx revealed a prior spinal fusion at T9-10 with osteosclerotic fatty replacement of the body at T9 and T10 probably related to an old discitis with healing. No other significant abnormalities were identified in the thoracic spine.

The patient was assessed in PT on May 5, 2009 for shoulder and low back conditions. He reports difficulty with reaching overhead and low back pain with prolonged sitting and standing. Shoulder pain in 6/10; low back pain varies from 4-8/10. X-rays have shown no fracture to the low back. He is using ibuprofen and Flexeril. Shoulder flexion was 113 degrees right and 158 degrees left. Lumbar flexion was normal but with pain. Deficiency was noted in right shoulder strength of 4/5 in the major groups. Impingement test was positive.

The patient attended a course of 12 sessions of PT from May 12, 2009 to June 11, 2009. PT notes are reviewed: The patient feels stiff in the AM and loosens up during the daytime (05-12-09). He reports low back pain of 3/10 before therapy (05-14-09). He reports low back pain of 5/10 (10-18-09). He reports low back pain of 6-7/10 (05-20-09). Per patient lumbar MRI revealed a pre-existing disc problem (05-27-09). He is having some difficulty with low back exercises (05-28-09). He reports minimal pain to both right shoulder and low back. He had no problems on the weekend and is doing better (06-01-09). Standing for long periods increases his low back pain; sitting down relieves the pain (06-04-09). He reports 60-70% improvement of shoulder pain and 20-25% resolution of low back pain (06-09-09). His low back is unchanged. He will be seeing a neurologist for headaches (06-11-09).

The patient is discharged from PT xx weeks post-injury. He has constant shoulder pain of 6/10 and lower back pain of 4/10 at best and 8/10 at worst. Right shoulder flexion is to 113 degrees. Trunk flexion is normal. He points to lumbar region as his problem since the injury but feel it may have exacerbated his existing thoracic fusion. He is doing HEP and is planning to see a neurologist for headaches and dizziness. Lower extremity motor strength is full.

The patient was provided a specialty consultation on July 13, 2009. He was struck from behind by a truck while kneeling over. He was evaluated at a hospital and released to his provider who has been providing medications and PT. He has brief periods of relief with recurring constant back pain that varies from 3-8/10. 90% of his symptoms are in the back. He also reports stabbing pain in the right leg with numbness and tingling at the buttocks and posterior thigh. The sensations are intermittent and vary from 0-6/10. PT has provided temporary relief. He has not had any other treatments. He is using Metformin, Lisinopril and ibuprofen. He has normal gait. Bilateral hip range of motion is full and pain-free. Motor strength is normal. Reflexes are symmetrical. Sensation is normal. Valsalva and straight leg raise are negative. X-rays taken this visit reveal, decreased disc height L4-5 disc and a claw spur on the right side of L4-5. Thoracic x-rays show a possible anterior fusion of T9-10. Thoracic MRI was reviewed. Assessment is lumbago, lumbar internal disc derangement, lumbar radiculopathy and thoracic spine pain. Conservative treatment is planned. He is recommended to loose weight. Updated lumbar MRI and a thoracic CT scan are planned.

The patient was reassessed in PT on July 16, 2009. He is reporting continuing right lower extremity symptoms. His average pain level is 3/10. Hip and quadriceps strength is noted as 4+/5 on the right. He is referred for an additional 12 sessions of PT for core stabilization.

Updated MRI of August 15, 2009 was given impression of internal disc derangement L4-5 and L5-S1, and a 4 mm right subarticular disc protrusion at L5-S1 without neural displacement.

The patient was reevaluated on September 4, 2009. The patient is working light duty. Sitting down is painful. He reports back pain of up to 8/10 which is 90% of his problem. 10 percent of his problem is right lower extremity pain that goes from the buttock to the posterior thigh. This is described as a stabbing pain. He also reports some increased thoracic pain from an old injury. He has not seen any physician visits for the old injury. The neurologic exam is unremarkable except for decreased right Achilles reflex. Assessment is annular tear, lumbago and thoracic spine pain. Recommendation is for thoracic CT scan and epidural injection right L5-S1.

A peer discussion was conducted on September 23, 2009 regarding an epidural injection per a phone note.

At reevaluation on October 7, 2009 the patient reported an increase in symptoms despite working light duties. Most of his pain is stabbing pain in the lumbar grouping. This can escalate to 8/10. His right buttock and thigh pain can escalate to 6/10. Right straight leg raise is positive and he has difficulty keeping his right leg straight. Diagnosis now includes lumbar radiculopathy. A denial of epidural injection has been received with note that he does not meet the required criteria. He does have a well-documented work injury as well as correlative lumbar pathology per MRI and objective neurological findings. Reconsideration is requested.

The patient was most recently reevaluated on October 9, 2009. Examination noted a positive right straight leg raise and a diminished right Achilles reflex. As he cannot take needed medications during work, he is taken off work.

Request for lumbar transforaminal ESI injection with selective nerve root block was considered in review on November 9, 2009 with recommendation for non-certification with rationale that radiculopathy is not documented by physical examination. No electrodiagnostic studies have been submitted for review. There is no evidence of nerve root compression on the MRI. There was no objective documentation regarding the patient's failure to respond to conservative management measures such as PT, medications and exercises. Further there was no documentation that the procedure will be in adjunct with evidence-based exercise program aimed at restoration of function. Lastly, the specific level desired for injection was not clarified. A peer discussion was attempted but not realized. The records reviewed consisted of four pages.

Request for reconsideration, lumbar transforaminal ESI injection with selective nerve root block was considered in review on November 23, 2009 with recommendation for non-certification with rationale that the documents submitted do not show that the patient has failed conservative care. It is only mentioned that the patient has been given Relafen and Soma. There is no mention of physical therapy notes, or other measures of conservative care. Additionally, the MRI submitted for review does not show evidence of neural impingement. Contact was made with an assistant who was not sure if PT had been provided as no notes were available.

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

ODG 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 by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

The first documentation of radiating low back pain with numbness and tingling into the right buttock and posterior thigh region is on July 13, 2009, approximately 90 days post injury. The patient has been through a course of PT without mention of these symptoms in the PT notes. On July 13, 2009 he has normal motor strength, symmetrical reflexes, normal sensation and a negative Valsalva and straight leg raise. He is recommended to loose weight, but his weight is not reported. PT assessment of July 16, 2009 noted gross hip and quadriceps strength of 4+/5 on the right. 12 additional sessions of PT were recommended for core stabilization, but completion of additional therapy has not been clarified. Updated MRI of August 2009 revealed internal disc derangement L4-5 and L5-S1, and 4 mm right subarticular disc protrusion at L5-S1 without neural displacement. X-rays have shown, decreased disc height L4-5 disc and a claw spur on the right side of L4-5. On September 4, 2009 the neurologic exam is unremarkable except for decreased right Achilles reflex. With increased symptoms noted in October 2009 and right straight leg raise is positive.

The first line reviewer appears to have had only four pages of medical records. It is not clear what medical records were available to the second line reviewer, but there is indication that few records were provided. While some radiation of pain is appreciated, this is not indicative of radiculopathy as facet mediated pain and discogenic pain can extend to the buttocks and posterior thigh. While report of a diminished right Achilles reflex is appreciated, throughout the records the reflexes are consistently noted as symmetrical. While the patient's recent increased in symptoms is appreciated, and his attendance of a course of 12 sessions of PT is noted, the medical records do not include electrodiagnostic studies to further assess a possible radiculopathy. Imaging has not shown a neurocompressive lesion. Lacking electrodiagnostic findings of a radiculopathy and lacking a neurocompressive lesion on imaging, the patient would not meet guideline criteria for the requested intervention.

Therefore, my recommendation is to agree with the previous non-certification for a lumbar transforaminal ESI injection with selective nerve root block right L5-S1.

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
- 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 - Lumbar Chapter (12-03-2009), 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. (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. 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. 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.

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