

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: 01/12/2010

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 epidural steroid injection at 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 06-20-07 55 pp - treatment notes, Pain Management Program- through September 2007
- o 11-27-07 LESI #1 procedure report from Dr. Rosenstein
- o 11-30-07 EMG/NCV report from Dr.
- o 08-23-07 Thoracic and Lumbar x-rays read by Dr.
- o 12-28-07 LESI #2 procedure report from Dr.
- o 01-08-08 MMI-Impairment report from Dr. DO
- o 06-26-08 Utilization Review report for 10 addition sessions of CPMP
- o 07-02-08 Follow-up report from Dr.
- o 07-16-08 FCE, unsigned
- o 08-06-08 Peer Review from Dr.
- o 06-25-09 LESI #1 procedure report from Dr.
- o 07-13-09 LESI "#2" procedure report from Dr.
- o 10-14-09 Follow up report from Dr.
- o 10-22-08 Letter-response to Peer Review, from Dr.
- o 11-03-08 Peer Review Addendum from Dr.
- o 11-04-09 LESI #3 procedure report from Dr.
- o 11-17-08 Follow-up report from Dr.
- o 03-19-09 Follow-up report from Dr.
- o 12-02-09 Follow-up neurologic report from Dr.
- o 12-04-09 Fax request for lumbar epidural injection from Dr.
- o 12-10-09 Adverse Determination Letter, initial from Forte
- o 12-10-09 Letter of Appeal from Dr.
- o 12-11-09 Fax request for reconsideration for denied lumbar ESI from Dr.
- o 12-18-09 Adverse Determination Letter, for reconsideration,
- o 12-22-09 Request for IRO from the provider
- o 12-23-09 Confirmation of Receipt of IRO request from TDI
- o 12-23-09 Notice of IRO reports as attached for the patient's attorney
- o 12-28-09 Notice of Case Assignment for IRO from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient is who sustained an industrial injury to the low back on xx/xx/xx associated with driving a forklift over train tracks.

From June through September 2007 the patient attended a chronic pain management program consisting of 20 full day sessions which included physical therapy, psychological counseling and spiritual concepts training. Improvements in mood and functioning were noted. The patient was interested in returning to school and entering a business career, perhaps insurance. He has not lost weight but he has a very good attitude. He learned coping skills to deal with and reduce anxiety and stress. During August and September 2007 he participated in physical therapy.

Thoracic and lumbar x-rays taken on August 23, 2007 showed an unremarkable thoracic and lumbar spine.

Lumbar MRI performed October 6, 2007 showed at L5-S1 a right paracentral 3 mm disc protrusion and multilevel facet disease. Multilevel minimal lumbar and lower thoracic spondylosis and disc bulges. Epidural lipomatosis.

The patient underwent an initial lumbar epidural steroid injection (LESI) on November 27, 2007 which increased his symptoms. A second LESI was administered on December 28, 2007 with unreported results.

EMG/NCV studies were performed on November 30, 2007. Per the examiner, the claimant denies any pain radiating into the hips or legs, but he does have some chronic numbness in the right leg that he attributes to his prior right leg fracture (tibia/fibula ORIF 1986) and swelling.

An impairment examination was conducted on January 8, 2008. The examination showed normal neurologic function. The examiner determined the claimant could do light duty work.

The patient underwent an FCE on June 16, 2008. The patient had increased his whole person functioning 17% and would be able to perform medium duty (to 70 pounds). His job requires occasional lifting of 50 pounds. At this examination, the lower extremity pinwheel examination was normal.

The patient was reevaluated by neurology on July 2, 2008 for low back pain and right leg numbness. An MRI scan showed a 3 mm central-to-right paracentral disc protrusion with annular tear at L5-S1. He also has epidural lipomatosis. He is attending a chronic pain rehabilitation program. An MMI evaluation was performed in January 2008 which determined him at MMI with zero impairment. He states the CPMP exacerbated his low back pain to some extent. He is again taking his medications including Relafen, Skelaxin and tramadol, which he reports have increased his GERD symptoms. The neurologic examination is normal.

A Peer Review was conducted on August 6, 2008. The patient is 5' 10" and 350 pounds. Gait is normal. Straight leg raise is negative bilaterally. Motor strength is normal. Sensation is diminished over the right leg in a stocking glove fashion 2-3 inches below the right knee. Right ankle reflex is diminished. EMG/NCV of November 30, 2007 was normal. Sub Rosa investigation of December 2007 showed the claimant carrying and unloading packages and carrying a case of beer. Per a report of December 27, 2007 a LESI increased his pain. A second LESI was provided on December 28, 2007. A request was made by his treating orthopedist in April 2008 for the patient's MMI rating to be revised to 5%. Per the reviewer, the patient has had prolonged medical treatment with a lumbar MRI identifying no acute structural change. Physical exam findings identified exaggerating with stocking and glove anesthesia, normal strength and negative straight leg raising. The patient's lumbar strain has resolved as noted by the doctor who found him to be at MMI with 0% impairment. There is no need for ongoing medications.

The patient's orthopedic provider disagreed with this report on October 22, 2008. While the patient has improved, he still has some residual lower back pain, for which he is being seen. Continued use of medications is needed. The Peer Review physician responded noting the claimant's MRI identified pre-existing normal disease of the life findings which, per ODG, are found in 93% of the asymptomatic population. The findings on MRI are not related to the claimant's work event, per a (cited) Texas Supreme Court Decision.

The patient was seen in follow-up by his orthopedic provider on November 17, 2008. He has completed the CPMP. Per an FCE he was released to Medium work (up to 70 pounds). He is currently not working. He reports back pain of 8/10 without medications and 5/10 with medications. He was told by DARS that he could return to his previous work, but he has been terminated. Motor strength is normal. Sensation is grossly normal. He was given a note indicating he could do light work up to 25 pounds and will return to DARS to seek some retraining.

The patient returned on March 19, 2009 and reported some improvement but was essentially unchanged in regard to symptoms and examination findings. He remains without employment.

According to a procedure report dated June 25, 2009 the patient underwent LESI #1 on this date.

According to a procedure report dated July 13, 2009 the patient underwent a LESI #2 on this date.

Per a procedure report dated October 14, 2009 the patient is being considered for additional LESI. Per the provider his last LESI was provided on 07-13-2009 and provided 80-% to 90% relief.

The claimant was seen in follow-up on December 2, 2009 in neurology for chronic lower back pain and right lumbar radiculitis. He has completed a Chronic Pain Program. He does extremely well with lumbar epidural steroid injections. His last LESI was on November 4, 2009. He reports at least 80% improvement with LESI. He rates his current pain level as 5/10. The cold weather has increased his pain. He is using tramadol, nabumentone and Skelaxin. On examination, there is no tenderness in the lumbar spine. Lumbar flexion is to 80 degrees and other ranges are to 10 degrees. Patellar reflexes are full and symmetrical. Achilles

reflex is absent on the left. Motor strength is full and straight leg raise is negative bilaterally. Recommendation is for a second LESI. A DDE is scheduled for December 16, 2009.

Request for LESI at L5-S1 was considered in review on December 10, 2009 with recommendation for non-certification. Per the reviewer, the patient had completed a CPMP, a tertiary care program used when other forms of care have been exhausted. There was a November 4, 2009 LESI with 80% relief. There are no current imaging or electrodiagnostic studies. The prior EMG showed no evidence of radiculopathy. ODG criteria had not been met.

The orthopedic provider requested appeal in a letter of December 10, 2009. He does very well with LESI. The LESI of November 4, 2009 provided 80% relief. A second LESI is desired at L5-S1. No additional clinical or diagnostic information was submitted.

Request for reconsideration for LESI at L5-S1 was considered in review on December 18, 2009 with recommendation for non-certification. Per the reviewer, the most recent exam reveals negative sciatic tension signs. The neurological exam reveals no motor weakness. He does have a depressed ankle jerk, but this is his non-painful side. He has undergone 3 previous LESI request is for a fourth LESI. He fails to meet ODG guidelines which require at least 6-8 weeks between LESI. In addition, it is this reviewer's understanding that ESIs should not be done in the presence of epidural lipomatosis which was noted on his MRI scan (although this is not mentioned in ODG).

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

ODG supports LESI 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. Chronic duration of symptoms (greater than 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration greater than 24 months. Criteria include, (1) Radiculopathy must be documented. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy.

The patient is 5' 10" and 350 pounds. He was treated for low back pain associated with a bumpy forklift ride over railroad tracks. Following conservative treatment and a CPMP, he was released to medium work but was terminated from his job. He reports continuing low back pain and numbness in the right lower extremity. Radiographs have shown an unremarkable thoracic and lumbar spine. MRI of 2007 revealed a right paracentral 3 mm disc protrusion at L5-S1 and multilevel facet disease, multilevel minimal lumbar and lower thoracic spondylosis and disc bulges and epidural lipomatosis. EMG/NCV of November 2007 was normal.

He was deemed MMI in January 2008 with zero impairment. The provider believes he has residual back pain and right leg symptoms and needs ongoing medications. Per an FCE he can do medium work, however, he does not have a job to return to and is planning retraining. His orthopedic provider believes he can only do light work. He is maintained on medications of tramadol, nabumentone and Skelaxin. Examination on December 2, 2009 demonstrated, no tenderness in the lumbar spine, flexion to 80 degrees, extension to 10 degrees, normal patellar reflexes, absent left Achilles reflex, full motor strength and negative straight leg raise bilaterally. A LESI was provided on November 4, 2008 (his third) with good response noted of 80% relief. The results of a Designated Doctor Examination planned for December 16, 2009 have not been reported.

Per the first line reviewer, there are no current imaging or electrodiagnostic studies and the prior EMG showed no evidence of radiculopathy. No additional clinical or diagnostic information was submitted with the appeal of the first line denial. Per the second line reviewer, the most recent exam reveals negative sciatic tension signs and the neurological exam reveals no motor weakness. He does have a depressed left ankle jerk, but this is his non-painful side. In addition, it was this reviewer's understanding that ESIs should not be done in the presence of epidural lipomatosis which was noted on his MRI scan (although this is not mentioned in ODG).

In regard to the claimant's chronic right leg numbness, the EMG/NCV report of November 30, 2007 states the following: He denies any pain radiating into the hips or legs, but he does have some chronic numbness in the right leg that he attributes to his prior right leg fracture (tibia/fibula ORIF 1986) and swelling.

References indicate that spinal epidural lipomatosis is most commonly observed in patients receiving long-term exogenous steroid therapy, but can also be seen in patients with endogenous steroid overproduction, obesity, or idiopathic disease. Conservative treatment, weaning from steroids, or weight loss can reverse the hypertrophy of the adipose tissue and relieve the neural compression.

The patient does not meet ODG criteria for LESI as there is no ongoing documentation of an active radiculopathy. EMG findings fail to support this diagnosis and MRI scan does not show significant neural compromise at the L5-S1 level. As previously noted, the patient has a depressed left ankle jerk, but this again is his non-painful side, and does not correlate with either EMG or MRI findings. Additionally, references indicate patients with epidural lipomatosis should be weaned from and/or avoid steroids. Therefore, my recommendation is to agree with the previous non-certification for lumbar epidural steroid injection at 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 (12-30-2009)- Epidural 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. 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.)

From Neurosurgical Focus: Spinal Epidural Lipomatosis: A Review of Its Causes and Recommendations for Treatment - Daniel R. Fassett, MD, MBA; Meic H. Schmidt, MD, Authors and Disclosures - Posted: 05/20/2004; Neurosurg Focus. 2004;16(4) © 2004 American Association of Neurological Surgeons

Spinal epidural lipomatosis is most commonly observed in patients receiving long-term exogenous steroid therapy, but can also be seen in patients with endogenous steroid overproduction, obesity, or idiopathic disease. With this condition, there is hypertrophy of the epidural adipose tissue, causing a narrowing of the spinal canal and compression of neural structures. A majority of patients will present with progressive myelopathy, but radicular symptoms are also common. Conservative treatment, weaning from steroids, or weight loss can reverse the hypertrophy of the adipose tissue and relieve the neural compression. If conservative management fails, surgery with decompressive laminectomy is also very successful at improving the patient's neurological symptoms. [<http://www.medscape.com/viewarticle/474908>]