

# P&S Network, Inc.

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## Notice of Independent Review Decision

### MEDICAL RECORD REVIEW:

**DATE OF REVIEW:** 06/30/2010

**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 Doctor (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**

Left lumbar transforaminal ESI at L4-5 outpatient 64483, 64484 (PRN 72275)

### **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.

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

According to the medical records and prior reviews the patient is a female who sustained an industrial injury to the low back on xx/xx/xx when attempting to place a client with Down's Syndrome on a toilet. Lumbar MRI performed on February 26, 2010 was given impression: Circumferential disc bulge at L4-5 narrows neural foramina. There is also a focal annular tear at that level.

Reconsideration was requested on May 2, 2010 for left L4 and L5 transforaminal ESI.

The patient was seen in pain management on May 4, 2010 following her initial LESI at L4-5 performed on April 26, 2010. She reports several days of muscle spasms from the injection, but they resolved and her back pain remained at pre-injection level. She reports a pain level of about 7/10. She reports some tingling in the left lower extremity to the foot but states the radiation she was experiencing down to her knee has resolved. Her pain is aggravated with activities. She has significantly reduced the amount of Hydrocodone she was taking from every 6 hours to four times in the past week. She is not currently attending therapy. On examination she can flex to 90 degrees. Straight leg raise is positive on the left for nerve tension in the left leg down to the calf.

Motor strength is 5/5. Reflexes are normal. Sensation is deficient to pinwheel in the left L5 dermatome compared to the right. She did get significant relief and recommendation is for a trial of left transforaminal ESI to better target the irritated nerve roots.

Request for left lumbar transforaminal ESI at L4-5 was considered in review on May 10, 2010 with recommendation for non-certification. A peer discussion was realized. The patient has been treated for a lumbar sprain and left leg pain. She is using Hydrocodone Q6H PRN, dosage not reported. She has had L4-5 intralaminar lumbar epidural steroid injection on April 26, 2010, which resulted in several days of muscle spasms, which resolved, but the back pain was the same as prior to injection. MRI of March 31, 2010 showed circumferential disc bulge at L4-5 narrows neural foramina with focal annular tear. A lumbar MRI performed on February 26, 2010 was noted but the findings were not reported. Reason for request: "To better target the nerve roots that are irritation." In peer discussion it was related that the patient had an interforaminal ESI on May 4, 2010 with some improvement in the back pain and radicular pain. There was some decrease in narcotics. The patient is working full duty, but is uncomfortable. They would like to do two nerve roots on the left with this transforaminal injection. The request does not meet the evidence-based practice recommendations. The injection therapy proposed was not accompanied by a presentation of a particular active rehabilitation program to be facilitated upon pain relief from the contemplated epidural steroid injection. The treating provider had not presented a plausible explanation for the failed response to the translaminar injection before another epidural injection was requested. The optimization of less interventional therapies was not demonstrated via objective documentation in this case. Overall, the appropriateness and medical necessity of the requested epidural steroid injection at L4-5 are not established.

A letter of reconsideration was submitted dated May 17, 2010. The patient has had conservative treatment since December 2009. She has had several weeks of PT that had to be interrupted for inability to make further progress. At that point a new MRI was ordered which showed an L4-5 disc bulge with an annular tear. She had an interlaminar ESI on April 26, 2010 with temporary relief of back pain but not her radicular pain. When seen on May 4, 2010 she was noted to have increased her consumption of Hydrocodone and was not able to initiate PT due pain levels. Examination showed positive left straight leg raise, normal motor strength and sensation deficit left L5 dermatome. In an effort to target the left L4 and L5 nerve roots and to decrease inflammation, annular tears can often involve inflammatory exudates which can cause tremendous irritation to the nerve roots at that level, and in an effort to directly target the nerve roots to allow her to get back to full duty work mode, it would be in her best interest to have a left L4 and L5 transforaminal ESI to directly target the nerve root involved. Also ESI will allow for exhaustion of conservative care and allow for further progress in PT.

Request for reconsideration left lumbar transforaminal ESI at L4-5 was considered in review on June 4, 2010 with recommendation for non-certification. A peer discussion was attempted but not realized. Per the reviewer, examination revealed positive straight leg raise test on the left. There was a deficit to pinwheel sensation on the left L5 dermatome compared to the right. Pursuant to the referenced guidelines, there is no relevant documentation provided to validate that the patient has had sufficient amount of conservative therapy as well as failure of the patient to respond to conservative measures such as evidence-based exercise program and medications prior to the proposed injections. There is no objective documentation of the patient's clinical and functional response from the previous injection that includes sustained pain relief, increased performance in the activities of daily living and reduction in medication use. As per the guidelines, an inadequate response from the previous injection precludes the necessity for a succeeding procedure. The latest medical report presented a cursory of limited neurologic motor sensory examination that validates the presence of radiculopathy in this patient. There is no impingement or compression of specific nerve roots documented in the MRI studies provided which supports the diagnosis of radiculopathy.

Request was made for an IRO.

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

Per ODG, epidural injections are 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. 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. 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. (7) Therapeutic phase: If after the initial block/blocks are given and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be required.

Imaging shows a circumferential disc bulge at L4-5, which narrows the neural foramina and a focal annular tear at that level. A focal neurocompressive lesion is not identified. Eight days following an initial ESI on April 26, 2010 the patient reports the injection resulted in several days of muscle spasms, which resolved, but her back pain remained at pre-injection level. She reported a pain level of 7/10 and some tingling in the left lower extremity to the foot but stated the radiation she was experiencing down to her knee had resolved. She did reduce her Hydrocodone intake significantly. Examination showed positive left straight leg raise for nerve tension in the left leg down to the calf, full motor strength, normal reflexes and sensation decreased in the left L5 dermatome compared to the right.

Per the first line reviewer, the patient had an interforaminal ESI on May 4, 2010 with some improvement in the back pain and

radicular pain. There was some decrease in narcotics. The patient is working full duty, but is uncomfortable. They would like to do two nerve roots on the left with this transforaminal injection. The request does not meet the evidence-based practice recommendations. The injection therapy proposed was not accompanied by a presentation of a particular active rehabilitation program to be facilitated upon pain relief from the contemplated epidural steroid injection. The treating provider had not presented a plausible explanation for the failed response to the translaminal injection before another epidural injection was requested. The optimization of less interventional therapies was not demonstrated via objective documentation in this case. Overall, the appropriateness and medical necessity of the requested epidural steroid injection at L4-5 are not established.

Per the reconsideration request, annular tears can often involve inflammatory exudates which can cause tremendous irritation to the nerve roots and a left L4 and L5 transforaminal ESI to directly target the nerve root involved would facilitate PT and return to work.

Per the second line reviewer there is no documentation that the patient has attempted physical therapy. The response to the initial epidural does not indicate sustained pain relief, increased performance in the activities of daily living or reduction in medication use (sic). There is no impingement or compression of specific nerve roots documented in the MRI studies provided to support the diagnosis of radiculopathy.

The patient is working full duties. There is no concern for a surgery. The appropriate time to assess for a repeat ESI would have been about June 8, 2010, 6 weeks post injection, as guideline criteria states a repeat injection may be considered if there is pain relief of at least 50-70% pain relief for at least 6-8 weeks. The duration of relief is not sufficient to warrant a repeat injection. It is also noted that a focal neurocompressive lesion is not identified on imaging and there is no indication that the patient is participating in an evidence based independent rehabilitation program.

Therefore, my recommendation is to agree with the previous non-certification for Left lumbar transforaminal ESI at L4-5 outpatient 64483, 64484 (PRN 72275).

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

X  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 (06-17-2010) Lumbar Chapter: 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.

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.

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.

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.

(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.