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Notice of Independent Review Decision

MEDICAL RECORD

REVIEW: DATE OF REVIEW: 06/11/2010

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) Doctor, 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

Injection, anesthetic agent and/or steroid transforaminal epidural; lumbar or sacral, single level (Bilateral lumbar ESI L4-5)

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 worker who sustained an industrial injury to the back when lifting a steel door. He reported low back pain that radiated into the anterior aspect of his left leg. Lumbar x-rays taken xxxxx showed mild remote compression of L1 with marginal steophytes.

The patient was examined chiropractically on xxxxx. Nerve root stretch tests were positive. The neurologic exam was normal. He would be provided chiropractic with physiotherapy for lumbar disc displacement.

Lumbar MRI performed on March 12, 2009 was given impression: Moderate to marked degree of narrowing in the central canal and neural foramina bilaterally at the L4-5 level. See description. Mild generalized multilevel disc protrusion as described. The findings also note: At L4-5 level, there is mildly diminished disc height and signal. A moderate degree of generalized disc protrusion is present. There is no focal extrusion or protrusion. Osteophytes arise from the posterior facet joints and there is posterior ligamentous hypertrophy. The findings are producing a moderate to marked degree of narrowing of the central canal and neural foramina bilaterally.

The patient was initially seen by his current medical provider on March 23, 2009. The patient has left-sided low back pain. He is 6 weeks post injury. He has had x-rays, an MRI and injections. He is using Atacand and Cartia XT. He smokes 1.5 packs daily. He is 5' 10" and 160 pounds. There is mild tenderness in the lumbar paraspinal musculature. Active flexion and extension are restricted. He has full passive range of motion without pain. Straight leg raise is positive on the left. He has a normal neurologic exam. Assessment is back pain and radiculopathy. He will initiate Tramadol. Lumbar ESI L4-5 is recommended.

The patient was reevaluated on March 26, 2009. A transforaminal epidural steroid injection was administered at L4-5.

The patient was reevaluated on April 16, 2009. His back pain and left lower extremity pain are "much less severe." Medications were refilled. The examination is unchanged.

Repeat lumbar radiographs were taken on February 2, 2010 and compared to the study of February 17, 2009. Six non-rib bearing lumbar type vertebral bodies are present with presumed hyperplastic ribs at T12. Mild superior end plate compression deformity L1 redemonstrated, stable. Multilevel disc degenerative changes are again noted without significant change. The lumbar spine remain stable in comparison to the prior study.

Neurodiagnostic studies performed on March 4, 2010 was given impression: 1. Subtle electrophysiological evidence of lumbar radiculopathy involving the L3 nerve roots bilaterally was recorded in the needle EMG

examination of the lower extremities. Lumbar radiculopathy was indicated by increased chronic reinnervation potential activity recorded in L5 innervated paraspinals and distal musculature within the lower extremities bilaterally. Absent cortical potentials recorded in bilateral tibial somatosensory evoked potential studies suggest mild bilateral S1 nerve root involvement. No electrophysiological evidence of distal mononeuropathy was recorded in these electrodiagnostic studies of the lower extremities.

The patient was reevaluated on March 29, 2010. He was doing well but is reporting a flare-up of low back and bilateral leg pain and would like to discuss injections for pain control. He is using Atacand, Cartia XT and Tramadol HCL. He continues to smoke. There is moderate tenderness in the bilateral lumbar region. Flexion and extension are moderately restricted and with pain. There is no tenderness at the SI joints. Motor strength is 5/5. Sensation is intact. Gait is normal. Recommendation is for transforaminal epidural injection bilaterally at L4-5.

Request for bilateral lumbar ESI L4-5 was considered in review on April 1, 2010 with recommendation for non-certification. A peer discussion was attempted but not realized. Per the reviewer, there is insufficient objective quantitative data submitted in the documentation for review that suggests the patient has had 50-70% relief from the first epidural steroid injection as required by ODG to warrant a repeat injection. The patient complains of low back pain and has had one epidural injection. Per ODG repeat injections should be based on continued objective documented pain relief, decreased need for medications, and functional response. The patient is age 62 and underwent MRI, which showed moderate to marked degrees of narrowing in the central canal and neural foramina bilaterally at the L4-5 level. There is also mild generalized multilevel disc protrusion noted. X-rays showed mild remote compression at L1 with marginal osteophytes. Clinical notes of 03/23/09 noted tenderness in the paraspinal muscles and decreased lumbar ROM. Clinical note of 03/26/09 notes the patient was provided a transforaminal ESI at L4-5. On

04/16/09 the report states his pain is still present but much less severe since his last ESI. On 03/29/09 the report states his back pain has returned and there was tenderness in the paraspinal muscles and decreased ROM. EMG/NCV studies have not been reported as supporting a compressive radiculopathy. The amount and duration of pain relief does not meet ODG criteria.

The patient was reevaluated by his provider on April 12, 2010. He is seen in follow up to discuss the denial of epidural injection. He had ESI last April with resolution of his pain and is now having recurrent flare-up and would like a repeat injection. There was no reason for the denial. His pain is in the low back and does not radiate to the extremities. He has not had any treatment for this flare-up. His examination remains unchanged. Request will be made for ESI at bilateral L4-5.

Request for reconsideration bilateral lumbar ESI L4-5 was considered in review on April 15, 2010 with recommendation for non-certification. Per the reviewer, the submitted examination findings noted completely normal neurologic examinations for the past two months. The clinical findings do not support a repeat ESI. Also, MRI shows stenosis but no overt nerve impingement. The ODG criteria have not been met.

The patient was most recently reevaluated by his provider on April 29, 2010. The patient reports increased low back pain and bilateral lower extremity pain and would like to appeal the denial of injection. He has full motor strength and intact sensation.

Gait is normal. Per the provider, he has back and BLE radicular pain. His pain is likely from radiculitis and he has responded well with complete resolution of pain one year ago with ESI. If he had radiculopathy, he would have focal neurological deficits from axonal compression and would do best with surgery. ESI are indicated and appropriate in this case.

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.

Examination of March 29, 2010 shows moderate tenderness in the bilateral lumbar region. Flexion and extension are moderately restricted and with pain. Motor strength is 5/5. Sensation is intact. Gait is normal. On April 12, 2010 the patient's pain is in the low back and does not radiate into the extremities. He has not had any treatment for this flare-up. The most current examination notes, increased low back pain and bilateral lower extremity pain. He has full motor strength and intact sensation. Gait is normal. Per the provider, he has back and BLE radicular pain. His pain is likely from radiculitis and he has responded well with complete resolution of pain one year ago with ESI. If he had radiculopathy, he would have focal neurological deficits from axonal compression and would do best with surgery.

Epidural injections are only a short-term option and not anticipated to resolve radiculopathy, but to allow for more aggressive rehabilitation and delay a possible surgery. The ODG criteria for epidural injections requires documentation of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) and the patient should be participating in

active rehab efforts. Imaging does not show a focal neurocompressive lesion. Nerve studies of March 2010 have shown subtle indication of L3, L5 and S1 radiculopathy bilaterally. However, clinically, the patient does not have radicular signs and he is not participating in active rehabilitation. As per report of April 12, 2010, he has not had any treatment for his more recent flare-up. The only treatment for his acute exacerbation appears to be continuation of his medications. According to the reviewed medical reports, the patient does not meet the criteria for epidural injections.

Therefore, my recommendation is to agree with the previous non-certification of the request for Injection, anesthetic agent and/or steroid transforaminal epidural; lumbar or sacral, single level (Bilateral lumbar ESI L4-5).

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 (05-18-2010) Low Back Chapter, Epidural steroid injections (ESIs), therapeutic:

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.

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.)