



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 6-9-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar epidural steroid injection with IV sedation MAC anesthesia

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

American Boards of Physical Medicine and Rehabilitation and Pain Management

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

•

PATIENT CLINICAL HISTORY [SUMMARY]:

MD., the claimant was seen for evaluation of her pain in the right knee, caused from the same fall it caused her shoulder injury in xx/xx. The claimant gets some pain that shoots down her leg into the foot and she describes some numbness and tingling in the posterior leg. She has tried a TENS unit for her shoulder and found some success. The evaluator discussed possible causes of knee pain. Physical therapy would be an option. The evaluator offered a cortisone injection, which she declined. She has also been offered an injection in the shoulder. The evaluator referred her to Dr. for further appropriate evaluation and treatment due to her back pain and paresthesias, the evaluator felt she may have radiculopathy.

10-28-09, unknown provider - the claimant was seen due to complaints of headaches x 3 days, neck and shoulder ache. On exam, she had cervical spasms and tenderness. The evaluator felt the claimant had tension headache/occipital neuralgia. She was provided with Toradol IM, samples for Soma and Celebrex were given. The claimant was advised to use heat treatment and refrain from further physical therapy until the pain is resolved. She was given a prescription for Vicodin and Ambien.

12-21-09 MD., the claimant was seen for followup evaluation of her shoulder MRI. The claimant was concerned regarding the pain including her back, knee and shoulder. She has multiple issues going on, which require different treatment approaches. The evaluator felt that an injection is a happy medium in terms of invasiveness between doing therapy and surgery. The evaluator was not anxious to do surgery because of her poor result with what he felt was a technically well executed operation of her contralateral shoulder done by Dr. She continues to have pain there. The evaluator provided a referral to see Dr. regarding possible lumbosacral radiculopathy. The claimant was referred to the xxxxx for evaluation of her chronic pain syndrome.

On 1-18-10 MD., the claimant is a female that presents today with a history of low back pain since 2008. She reported that this is a work injury and it started after she fell. She was doing a load, securing it. The load came undone, hit her, knocked her off balance and from that point she describes sacroiliac and coccyx pain into the tailbone area. The pain has significantly exacerbated with sitting in the coccyx area. She also reports that her right leg feels numb and has given out at times, but she has not fallen. She also localizes a lot of pain to the right sacroiliac joint, which has increased with sit-to-stand transfers and bed mobility. She quantifies her pain today as an 8/10, 10/10 at the worst, 5/10 at the least. Her medications include Proventil inhaler, over-the-counter antacids, naproxen 500 mg twice a day, lisinopril 10 mg daily.

On exam she has tenderness to palpation of her right SI joint. The sciatic notches were mildly tender, but the SI joint was very tender. She had little to no tenderness to palpation of the left SI joint. She had no problems with forward flexion, reproduction of

some pain with extension. Motor exam: Normal bilateral lower extremity strength of her lower extremities. She had normal bilateral sensation in L4, L5, S1 dermatomes. Maneuvers: Negative seated, negative supine straight leg raise. Deep tendon reflexes trace at the patella's, 2+ at the ankles bilaterally. Maneuvers: Negative seated, negative supine straight leg raise. Positive FABER maneuver on the right. Positive sacral distraction maneuver on the right. The evaluator felt the claimant had right sacroiliac joint pain and dysfunction and coccydynia. The evaluator reported the claimant's pain is most consistent with the sacroiliac problem given the etiology of the accident and the description she is providing today. The evaluator told her that she would benefit from the use of an SI belt to provide her with more support through the joint. He recommended a trial of Feldene anti-inflammatory to help if the naproxen was not helpful. She will be scheduled for a right SI joint injection under fluoroscopic guidance.

On 2-26-10, the claimant was evaluated by, PAC/ MD. The claimant is female being seen at the request alter referring physician xxxxx. She indicates the problem location is right shoulder, left shoulder, right buttock, left buttock, back, right thigh, right leg, head and neck. Pain is described as aching, burning, cramping, deep, dull, numbness, prickling, sharp, shooting and squeezing. Severity of condition is Pain scale varies and 7-8. This claimant's pain condition has existed for 2 years prior to her evaluation at this clinic. MRI of right shoulder and Reports were reviewed. Claimant indicates the following factors make the condition worse: lifting, standing, climbing, sitting, bending over and walking. Claimant indicates the following factors do not change the condition: medications and physical therapy. Claimant is experiencing nausea, weakness, sleep difficulty, headaches and constipation. The claimant was previously treated by the following physician(s): Dr. and many others. The claimant is a female referred for low back pain but she complains of pain in her head, both shoulder, low back, buttocks and down the right leg. She originally injured herself in xxxxx but she subsequently has been in multiple states until she came to xxxxx. She had surgery on her left shoulder by Dr. of xxxxx but she was discharged from that practice

because of "insurance issues." On exam, her gait is stable and station is mid position and normal.

Inspection and palpation of the bones, joints and muscles is unremarkable for the bilateral upper and lower extremities. Musculoskeletal exam reveals full range of motion, symmetric strength, and normal muscle tone without any atrophy or abnormal movements of the bilateral upper and lower extremities, head and neck, and trunk. Restricted ROM in the both shoulders. Spurlings test is negative on the right and left side. Straight Leg Raise test produces no pain in the lower extremities bilaterally. The Sacroiliac Joints are nontender to palpation bilaterally. Palpation of the facet joints at L3-4, L4-5 and L5-S1 on the right reveals moderate tenderness. Deep tendon reflexes are normal for the Biceps, Triceps, Brachioradialis, Patellar, and Achilles regions bilaterally. Touch sensations are normal for the upper and lower extremities bilaterally. The evaluator felt the claimant had cervicalgia, hypertension, low back pain, lumbago, and rotator cuff syndrome. The evaluator recommended MRI of the lumbar spine and consider an injection in the right shoulder. She declined medication management and will stay with her PCP.

3-17-10 MRI of the lumbar spine showed mild strengthening of the lumbosacral spine with loss of the lordotic alignment. Mild broad disc bulge at multiple levels with no significant central canal stenosis, no neural foraminal stenosis. There are mild degenerative articular facets.

3-29-10 Follow up with PAC MD. The claimant's physical exam showed full range of motion, no pain with SLR, DTR are normal. Sensation is normal for the upper and lower extremities bilaterally. The claimant will be scheduled for a lumbar epidural steroid injection with IV sedation. There were no changes to her medications. The evaluator also recommended an injection to her shoulder.

On 4-9-10, , MD., performed a Utilization Review. Per medical report dated 3/29/10, subjective complaints included pain in the low back and right lower extremity. Physical examination revealed moderate tenderness in the right lower lumbar facet joints. There is no documentation of root tension signs and a dermatomal distribution of neurologic deficits to establish the presence or radiculopathy. There is no documentation of an imaging study documenting focal nerve root compression. There is no clarification of the lumbar levels for which the proposed injection is intended. Submitted records fail to objectively document exhaustion of conservative treatment such as medications, activity modification, and physical therapy at this time. With insufficient clinical justification for the proposed imaging study, medical necessity of lumbar ESI is not established. Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced above; this request for Lumbar ESI with MAC Anesthesia is not medically necessary.

On 5-11-10, MD., performed a Utilization Review. He noted that the appeal request for lumbar epidural steroid injection with IV sedation; appeal MAC anesthesia is not supported by the submitted clinical information. The available medical record indicates the claimant originally sustained work related injuries on xx/xx/xx. On this date the claimant fell onto her buttocks. She has subjective complaints of low back pain with radiation into right lower extremity that are not validated on physical examination. MRI of the lumbar spine dated 3-17-10 shows no evidence of significant neuro compressive lesions. There is mild left neural foraminal steno at L4-5 which is inconsistent with claimant's subjective reports. The claimant is noted to have evidence of posterior element tenderness on physical examination without evidence of motor strength loss, sensory deficit, or abnormal reflexes. As such, the claimant has no clinical evidence of radiculopathy and per ODG lumbar epidural steroid injection would not be indicated. Therefore, the request for MAC anesthesia would not be medically necessary.

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

Medical records reflect a claimant with multiple complaints of pain to the right shoulder, left shoulder, right buttock, left buttock, back, right thigh, right leg, head and neck. On 2-26-10, her musculoskeletal exam revealed full range of motion, symmetric strength, and normal muscle tone without any atrophy or abnormal movements of the bilateral upper and lower extremities, head and neck, and trunk. There was restricted range of motion in the both shoulders. Spurlings test is negative on the right and left side. Straight Leg Raise test produced no pain in the lower extremities bilaterally. The Sacroiliac Joints are nontender to palpation bilaterally. Palpation of the facet joints at L3-4, L4-5 and L5-S1 on the right reveals moderate tenderness. Deep tendon reflexes are normal for the Biceps, Triceps, Brachioradialis, Patellar, and Achilles regions bilaterally. Touch sensations are normal for the upper and lower extremities bilaterally. There is an absence of documentation showing evidence of radiculopathy on exam. Per ODG, an epidural steroid injection is recommended if radiculopathy is documented.

Objective findings on examination need to be present. There is an absence in documentation showing evidence of radiculopathy on exam and the MRI does not warrant epidural injection in this case. There is no evidence of loss of reflexes, strength loss, or sensory loss. Therefore, the request for lumbar epidural steroid injection is not reasonable or medically necessary.

ODG-TWC, last update 5-18-10 Occupational Disorders of the Low Back – Cervical 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) This RCT concluded that caudal epidural injections containing steroids demonstrated better and faster efficacy than placebo. (Sayegh, 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)**