



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC
CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 8-31-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar epidural steroid injection

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

- 6-1-08 X-rays of the lumbar spine.
- 7-28-08 MRI of the lumbar spine.
- 10-1-08 EMG/NCS performed by DO.
- MD., office visits on 10-13-08, 11-4-08, 11-25-08, 12-18-08, 2-12-09, 3-12-09, 4-7-09, 5-19-09, 5-28-09, 6-18-09, 7-20-10, and 8-3-10.
- 12-10-08 lumbar intraspinal injection performed by Dr..
- 12-29-08, 1-28-09 Myoneural injections x 6 sites performed by Dr..
- 8-17-09 MD., performed a Designated Doctor Evaluation.
- 11-5-09 MRI of the lumbar spine.
- 7-26-10 Utilization Review performed by, DO.
- 8-6-10 Utilization Review performed by , MD.

PATIENT CLINICAL HISTORY [SUMMARY]:

6-1-08 X-rays of the lumbar spine was normal.

7-28-08 MRI of the lumbar spine showed moderate discal degeneration L4-L5 with broad based disc bulging and evidence for posterior anular tear. Spinal canal remains patent. Neural foraminal are mildly narrowed. Mild discal degeneration L1-L2 with small superior, inferior endplate Schmorl's nodes. Spinal canal and neural foramina are patent.

10-1-08 EMG/NCS performed by DO., showed bilateral acute on chronic denervation potentials primarily in L5 innervated limb muscles with corresponding bilateral paraspinal denervation consistent with L5 radiculopathy.

10-13-08, MD., the claimant suffered an on the job injury in. He has been an for approximately three to four years. He states he is always bent over or stooping and on his knees throughout the day. On this particular day he began to feel a very sore and tight sensation across the low back. He states since then the pain has become worse. He did go see Dr. who prescribed the patient Gabapentin and Ibuprofen with good relief. He also was prescribed physical therapy without relief. He underwent an MRI of the lumbar spine that showed a broad based bulging disc at L4-5 with post annular tearing. The radiologist felt epidural injections may help with this. He has now been referred here by Dr. for possible treatment. On exam, Straight leg raises lying cause pain at 35 degrees. Femoral nerve stretch on the left is positive. There is pain with flexion and extension of the lumbar spine. Strength is 5/5. Biceps are 2 +, Triceps are 2 +, Brachial radialis are 2 +, Patellar are 3 + bilaterally, Achilles are 2+ bilaterally. The evaluator recommended blood work, series of two intraspinal injections with trigger point injections, prescription for Celebrex, Biofreeze, and Ultracet. The claimant is to continue with a home exercise program.

Follow up with Dr. on 11-25-08 notes the claimant complains of low back pain with radiation down the lower extremity. Epidural steroid injection were recommended but denied. On exam, he has tenderness at the lumbar paraspinal muscle and gluteal region. The evaluator recommended epidural steroid injection. The claimant was continued with his medications and a home exercise program.

On 12-10-08, the claimant underwent lumbar intraspinal injection performed by Dr..

Follow up with Dr. on 12-18-08 notes the claimant reported initially 100% relief of pain, then 80% pain relief. Overall improvement was 30%. The evaluator recommended a second epidural steroid injection.

12-29-08, 1-28-09 Myoneural injections x 6 sites performed by Dr..

Follow up with Dr. on 1-22-09 notes the claimant reported first 100% pain relief then 80% pain relief post the injection. The long term improvement has been 30% improvement of his pain. The evaluator recommended a third epidural steroid injection.

Follow up with Dr. on 2-12-09 notes the claimant reported pain to the low back and left testicle and lower extremity. He underwent a third epidural steroid injection on 1-28-09 and reported relief with the injections. The evaluator recommended a lumbar discogram.

Follow up with Dr. on 5-19-09 notes the claimant continues with some pain to the lower back and gluteal region. He is not taking more medications. He continues to have increased pain. The evaluator recommended a rehab program and continue to seek approval for a work conditioning program.

Follow up with Dr. on 7-30-09 notes the claimant has ongoing pain and discomfort. The request for lumbar discogram was again denied. The claimant is pending the result of a hearing.

8-17-09 MD., performed a Designated Doctor Evaluation. He certified the claimant had reached MMI and awarded the claimant 5% impairment rating.

11-5-09 MRI of the lumbar spine showed mild to moderate lumbar spondylosis most prominent at L4-L5. No significant change since 7-28-08.

Follow up with Dr. on 7-20-10 notes the claimant has a history of left sided radiculopathy with ongoing pain and discomfort. On exam, the claimant has reproducible trigger point tenderness in the quadratus lumborum, gluteus maximus and gluteus medius. He has decreased sensation to the left lower extremity below the knee in the L4 distribution. SLR is positive on the left at 45 degrees. Femoral nerve test is positive. Gait is slow. Range of motion is decreased. The evaluator recommended a series of two epidural steroid injections with trigger points.

7-26-10 Utilization Review performed by, DO., notes the reviewed had not determined the medical necessity of this request per the available information and evidence-based guidelines. There was no indication from the available documentation/information that the previous series of ESIs provided any specific, significant overall long-term pain relief as there was mention that after the third ESI that was done only provided one day of relief. Also, the patient was already determined to be at maximum medical improvement previously and his most recent MRI imaging did not reveal any changes compared to the prior MRI. According to the Official Disability Guidelines regarding ESI treatment, "the purpose of the 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. Radiculopathy must be documented by objective findings on examination need to be present. If after the initial block/blocks are given and found to produce pain relief of at least 50-70% for at least 6-8 weeks, additional blocks may be required. Current research does not support a routine use of "series-of-three" injections in either the diagnostic or therapeutic phase. The Guides recommend no more than two ESI injections for the initial phase and rarely more than two for therapeutic treatment." There

was also no indication from the available documentation/information that the patient's radicular symptoms are more predominant compared to other pain generators as there was mention of trigger points that were present as well. Therefore, the medical necessity has not been established for the additional lumbar ESI treatment.

8-3-10 Letter provided by Dr. notes the claimant is a patient with pain to the lower back and lower extremity. He has a history of left sided radiculopathy. He has ongoing pain and discomfort. His pain has been persistent. He has undergone a worker's compensation hearing recently. Dr. has requested that I see the patient secondary to persistent pain. He has returned to work and is working 10-12 hours a day. He has severe pain especially at the end of the day to the lower back and down the left lower extremity past the knee. He noted he has specific areas of active and reproducible trigger point tenderness noted to the quadrates lumborum, the gluteus maximus and the gluteus medius. He has decreased sensation to the left lower extremity below the knee in the L 4 distribution. Straight leg rises are positive on the left at 45 degrees. Femoral nerve test is positive. His gait is slow and, guarded and antalgic. He has limited range of motion with lateral bending, lateral rotation, flexion and extension. The evaluator recommended lumbar epidural steroid injection series of two.

8-6-10 Utilization Review performed by MD., notes the reviewed determined the lack of medical necessity for this request in accordance with evidence-based guidelines. The Official Disability Guidelines criteria for the use of epidural steroid injections state, "Radiculopathy must be documented. Objective findings on examination need to be present. If after the initial block/blocks are given and found to produce pain relief of at least 50-70% for at least 6-8 weeks, additional blocks may be required. Current research does not support the routine use of "series-of-three" injections in either the diagnostic or the therapeutic phase. The Guides recommend no more than two ESI injections for the initial phase and rarely more than two for therapeutic treatment." In this situation, criterion regarding repeat injections is the only applicable criteria. The patient did have "series of three" epidural steroid injections performed in 2008. There was no documented evidence that the patient did well with these injections and specifically that the patient had 50% to 70% pain relief for at least six to eight weeks after these injections. There were two consecutive calls over two consecutive days made to Dr.. Unfortunately, these phone calls were not returned. Therefore, at this point, the repeat epidural steroid injection would not be warranted in accordance with the Official Disability Guidelines.

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

THIS CLAIMANT'S MRI SHOWS DEGENERATION AND NOT A DISC HERNIATION. A LUMBAR EPIDURAL STEROID INJECTION WOULD NOT BE INDICATED IN THIS CIRCUMSTANCE. THEREFORE, THE REQUEST FOR A LUMBAR EPIDURAL STEROID INJECTION IS NOT ESTABLISHED AS MEDICALLY NECESSARY.

ODG-TWC, last update 8-30-10 Occupational Disorders of the Low Back – 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) (Delport, 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)