



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



DATE OF REVIEW: 9-9-10

CLAIMS EVAL

IRO CASE #:

*Utilization Review and
Peer Review Services*

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

- 2-9-10 MRI of the cervical spine.
- 4-26-10 MRI of the lumbar spine.
- MD., office visits on 6-2-10, 6-30-10 and 8-4-10.
- 7-20-10 EMG/NCS of the upper extremities performed by MD.
- 7-5-10 Letter of reconsideration provided by MD.
- 7-12-10 MD., performed a Utilization Review.
- 7-23-10 MD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

2-9-10 MRI of the cervical spine showed a central disc herniation at C6-C7. An element of central stenosis is present. Loss of normal lordosis which might be related to the claimant's positioning and/or spasms.

4-26-10 MRI of the lumbar spine showed a broad based disc herniation at L5-S1 circumferential disc bulge at L4-L5.

6-2-10, MD., the claimant is a male who was injured on the job when a manhole lid on a tanker blew off and the pressure, greater than 1300 pounds, threw him back against a rail. Since then, he has been experiencing pain from his neck down his spine with numbness in his hands and feet with increased headaches. The headaches start in the posterior aspect of his head and radiates forward. He did undergo chiropractic therapy with Dr. for over 2 months which consisted of passive therapy. He does not feel that the therapy helped with his pain. He did undergo some diagnostic studies but he did not

have a copy of MRI reports. He describes his pain as intermittent, occurring daily, worse in the morning after getting up and at night when trying to sleep. Sitting and lying down seem to make his pain worse. Standing and walking does alleviate some of his discomfort. He reports his pain as a 5/10 on the pain scale. On exam, the claimant ambulates without assistance devices, non antalgic gait, tolerates positional changes with minimal discomfort, diffuse paraspinal muscular tenderness without hypertonicity, restricted range of motion in both cervical and lumbar spine, negative straight leg raise, negative sacroiliac joint/sciatic notch tenderness. Diagnosis: Cervicalgia, thoracic pain, low back pain. The evaluator recommended medications (Vicodin, Motrin 800 mg and Robaxin 500 mg). The claimant is to return in 30 days.

Follow up with Dr. on 6-30-10 notes the claimant was irritated and angry. The evaluator was able to obtain a copy approximately 1 week later. He wants to undergo cervical and lumbar injections. He complains of neck pain that radiates down into his mid back with numbness in both arms and hands and low back pain that radiates down both legs posteriorly in and L5-S1 dermatomal pattern with numbness in lower legs. Cervical MRI dated 2/09/10 gives the impression of a central disc herniation of 3mm at C6 - 7 with slight flattening of thecal sac and the loss of normal lordosis. Lumbar MRI dated 4/26/10 gives the impression of a broad base disc herniation of 5 mm at L5 - S1 and circumferential disc bulge at L4 - 5 of 4 mm. The evaluator will request a lumbar epidural steroid injection. Exam of the cervical spine showed minimally restricted range of motion in all planes with paraspinal musculature discomfort and hypertonicity, without spinous process or nuchal ridge tenderness. Lumbar spine showed restricted range of motion in all planes with discomfort, diffuse paraspinal muscular tenderness with hypertonicity, straight leg raise on the right and the left produces leg discomfort with dorsiflexion, negative SI/sciatic notch tenderness. Patient ambulate without assistance devices, non antalgic gait, tolerates positional changes with minimal discomfort. Exam is within normal limits with respect to motor power, reflexes, and sensory exam. The claimant was continued on his medications. The evaluator requested a lumbar epidural steroid injection.

7-5-10 Letter of reconsideration provided by, MD., notes this gentleman has failed conservative therapy including medications and physical therapy. He has evidence of large herniated disks at L4-5 and L5-S1. He has a positive straight leg raising test bilaterally. His patellar and Achilles reflexes are diminished bilaterally. The plan is to do a lumbar epidural steroid injection at L4-5, please have this request reviewed by an anesthesiologist who performs invasive pain management 100% of the time just like he did.

7-12-10, MD., performed a Utilization Review. The claimant is 5 months out from lumbar injury with ongoing radicular symptoms and request is now for lumbar ESI (no identified level.) No unequivocal signs of radiculitis on exam. 4-26-10 Lumbar MRI showed broad based disc herniation at L5-S1. Circumferential disc bulge at L4-L5. Based on the lack of hard exam findings for lumbar radiculitis, and the lack of neural impingement on MRI and the lack of identified level for the ESI, according to ODG (Low Back and Pain) Treatment Guidelines, the request is not medically necessary.

7-20-10 EMG/NCS of the upper extremities performed by, MD., was normal.

7-23-10, MD., performed a Utilization Review. The claimant is a male with a date of injury on xx/xx/xx. The claimant is 5 months out from lumbar injury with ongoing radicular symptoms. This request is for lumbar ESI. There was a prior request that was denied. MRI on 04/26/2010 showed broad-based 5 mm disc herniation at L5-S1 and a 4 mm circumferential disc bulge at L4-L5. There were several inconsistencies in the clinicals provided. On the note dated 06/02/2010, there was a normal neurologic exam and a negative SLR. On the note dated 06/30/2010, there was positive SLR bilaterally, but a normal neurologic exam. According to a letter of reconsideration dated 07/15/2010, the claimant now has a positive SLR bilaterally and diminished reflexes Achilles and patellar reflexes bilaterally. This was all documented in a span of 6 weeks. The reviewer provided an adverse determination.

8-4-10 Follow up with, MD., notes the claimant was denied the epidural steroid injection. He evaluator reported he will file an IRO. The evaluator refilled his medications. On exam, the claimant has restricted lumbar range of motion. SLR bilaterally produces leg discomfort. Neurological exam is within normal limits. The evaluator continued to recommend a lumbar epidural steroid injection.

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

Medical records reflect the claimant has failed conservative therapy including medications and physical therapy. His MRI showed a broad based disc herniation at L5-S1 circumferential disc bulge at L4-L5. The treating doctor reflects the claimant has a positive straight leg raising test bilaterally. His patellar and Achilles reflexes are diminished bilaterally. Based on the records provided and evidence of radiculopathy on exam, the request for lumbar epidural steroid injection is reasonable.

ODG-TWC, last update 9-8-10 Occupational Disorders of the Low Back – Lumbar 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. (Savegh, 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)