



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WCN

DATE OF REVIEW: 2-9-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Epidural Steroid injection #3

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

American Board 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

- MD., office visits on 8-12-10 and 8-31-10.
- 8-20-10 MRI of the sacrum and coccyx.
- 8-20-10 MRI of the cervical spine.
- 8-20-10 MRI of the lumbar spine.
- MD., office visits on 9-28-10, 10-22-10, 12-14-10, and 1-11-11.
- 10-13-10 MD., the claimant underwent a caudal epidural steroid injection.
- 11-3-10 MD., the claimant underwent a caudal epidural steroid injection.
- 12-20-10 Utilization Review performed by MD.
- 1-19-11 Utilization Review performed by DO.

PATIENT CLINICAL HISTORY [SUMMARY]:

MD., the claimant comes in for an evaluation. He presents with low back pain that radiates to bilateral legs. The claimant reported that he was injured when the chair he was sitting in broke on xx/xx/xx. He reports that his left side will go numb and back pain with fullness. He has had previous laminectomy x 2 (last one in 2001) and cervical fusion surgeries, last one 2005-2006. The claimant has had occasional back pain before fall and was taking Mobic. On exam, the claimant has decreased range of motion. Decreased range of motion of cervical range of motion with numbness, left arm with Spurlings. DTR are symmetrical and normal. The claimant has pain with SLR bilaterally. X-rays of the lumbar spine showed multilevel spondylosis and disc collapse. Impression: Lumbar and cervical radiculopathy, possible sacral or coccyx fracture. Plan: MRI of the lumbar spine. Prescription provided for Mobic, Synthroid, Vicodin and Ambien. The claimant has continued at work at light duty.

8-20-10 MRI of the sacrum and coccyx showed no sacral or coccygeal deformity or malalignment. There is bilateral subchondral cyst or intraosseous ganglion present in the superior aspect of the sacroiliac joint consistent with osteoarthritis.

8-20-10 MRI of the cervical spine showed at C2-C3 mild bilateral facet arthrosis. There is mild left foraminal narrowing. At C3-C4, there is mild right and moderate left foraminal narrowing is present. At C4-C5 2 mm spondylotic left posterior protrusion

mildly indents the sac. There is mild left foraminal narrowing and no central canal stenosis. C5-C6, status post fusion, 2.5 mm bony left posterolateral protrusion and uncovertebral spur. C6-C7 status post anterior fusion. There is a 1 mm bony right posterior protrusion. There is no central canal or lateral recess stenosis and no moderate or marked foraminal narrowing. C7-T1, there is a 3.5 mm posterior right paracentral protrusion and annular tear moderately indents the sac is mild left foraminal narrowing.

8-20-10 MRI of the lumbar spine showed L1-L2 there is moderate disc space narrowing and 2 mm retrolisthesis of L1. There is a 2 or 3 mm symmetric broad based posterior protrusion mildly indents the sac. There is no central canal or lateral recess stenosis. There is mild bilateral foraminal narrowing present without nerve root displacement. At L2-L3, there is moderate disc space narrowing present with 4 mm retrolisthesis of L2. 4 mm broad based posterior protrusion with posterocentral and right posterolateral mild accentuation moderately indents the sac. There is also a 3 mm rightward listhesis of L2 on L3. At L3-L4, there is moderate disc space narrowing and 4 mm broad based posterior protrusion at posterocentral accentuation and posterocentral annular tear mildly indents the thecal sac. The central canal is not stenotic. There is mild bilateral facet arthrosis present. At L4-L5, there is moderate disc space narrowing with degenerative end plate changes. There is 8 mm leftward listhesis of L4 upon L5. There is a left laminotomy defect. There is a 5 mm bony and diskal or spondylotic broad based posterior protrusion with left posterior accentuation moderately indents the sac. There is bilateral facet arthrosis present. At L5-S1, there is a 2 mm retrolisthesis of L5 upon S1 4 or 5 nun posterocentral left paracentral protrusion abuts the sac. There is an associated annular tear, Moderate bilateral facet arthrosis is present. Marked left lateral recess stenosis is present. Mild right marked left foramina/ narrowing is present with marked effacement of the emanating left L5 nerve root sleeve/dorsal root ganglion. The S1 nerve root sleeves are unaffected.

8-31-10 MD., the claimant is a male who was seen for MRI results. The evaluator felt the claimant had lumbar and cervical radiculopathy, sacroiliac joint arthritis, status post laminectomy 4/5 with stenosis and left listhesis, cervical status post 5/6 ACDF with left foraminal stenosis. The evaluator provided the claimant with Vicodin and Ambien. The claimant was referred to Dr. and Dr.. The claimant is continued at work on light duty.

9-28-10 MD., the claimant is able to stand, sit and walk for more than 30 minutes. The claimant's pain level is 0-3/10. The claimant complains of low back pain that radiates to both lower extremities. The pain has been going on for weeks. His current medications include Mobic, Synthroid, Hydrocodone and Ambien. On exam, the claimant has poor toe walking. SLR is positive bilaterally. DTR are decreased. Plan: epidural steroid injection per ODG for neurological deficits.

10-13-10 MD., caudal epidural steroid injection.

10-22-10 MD., the claimant is able to stand for more than 30 minutes. He is able to sit and walk for more than 30 minutes. His pain level now is 0-3/10. The claimant

presents for follow up after caudal epidural steroid injection. The claimant has a diagnosis of lumbar radiculitis and HNP related to a work injury. The claimant noted greater than 50% improvement in his low back symptoms with the injection. He continues to have numbness and tingling in his bilateral legs. The evaluator recommended a second caudal epidural steroid injection.

11-3-10 MD., the claimant complains of low back pain that radiates to the left lower extremity. The claimant underwent a caudal epidural steroid injection.

12-14-10 MD., the claimant reports constant stabbing soreness, aching burning. The claimant reports overall improvement in pain by more than a half after the procedure. The claimant still has bothersome pain and gets shooting pain in the left leg. On exam, the claimant has poor toe walking, poor heel walking. DTR are decreased. SLR is positive on the left. The evaluator recommended a caudal epidural steroid injection, as the claimant had 6-8 weeks of 50% or greater in neurological deficits.

12-20-10 Utilization Review performed by MD., notes the claimant underwent two caudal epidural steroid injections on 10-13-10 and 11-3-10. The claimant's objective, functional response is not documented. There is no current detailed physical examination provided. The claimant is still able to stand for less than 15 minutes, sit for less than 30 minutes and walk for less than 15 minutes. Given the current clinical data, the request is not indicated as medically necessary.

1-11-11 MD., the claimant is able to stand for less than 15 minutes. He is able to walk for less than 15 minutes. His pain level is now 4-6/10. Pain level at the worst is 7-9/10 and at the best 0-3/10. The claimant reports his pain is constant shooting, stinging, burning numbness, tightening feeling. The claimant has no improvement in pain noted. He has worsening in pain. The claimant had over 50% relief of pain over 8 weeks with the epidural steroid injection. Assessment: Lumbar radiculitis, lumbar herniated nucleus pulposus. Plan: caudal epidural steroid injection. The evaluator reported the claimant had positive radiculopathy as evidence by poor toe walking. Poor heel walking, failure of conservative therapy, physical therapy, medications, etc, sensory deficit in the left L5 dermatome.

1-19-11 Utilization Review performed by DO., notes the claimant has had 2 epidural steroid injections claiming 50% relief x 8 weeks at the last note. However, there is insufficient documentation to back this claim up. He could not provide details on whether the claimant reduced his medications. The pain scores are lacking pre injection to verify the current pain scores are 50% improved. There is no indication that the claimant improved in functionality. Overall, he was able to sit/stand/walk for 30 minutes after the first epidural steroid injection but only for 15 minutes after the second for some of these parameters. There is a lack of clarity in pain scores as well as the MD references a huge range of pain scores in his notes so comparing these is relatively difficult. A third epidural steroid injection is not supported as per ODG.

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

BASED ON THE RECORDS PROVIDED, THERE IS NO INDICATION FOR REPEAT AND PERFORMING A THIRD EPIDURAL STEROID INJECTION. ODG NOTES THAT CURRENT RESEARCH DOES NOT SUPPORT A ROUTINE USE OF A "SERIES-OF-THREE" INJECTIONS IN EITHER THE DIAGNOSTIC OR THERAPEUTIC PHASE. ADDITIONALLY, THERE WAS NO OBJECTIVE DOCUMENTATION IN FUNCTIONAL IMPROVEMENT OR DECREASE IN THE USE OF MEDICATIONS THAT WOULD SUPPORT PERFORMING A THIRD EPIDURAL STEROID INJECTION. THEREFORE, THE REQUEST FOR A THIRD EPIDURAL STEROID INJECTION IS NOT REASONABLE/MEDICALLY NECESSARY.

ODG-TWC, last update 1-14-11 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](#)) ([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, reduction of medication use 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) Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
- (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 supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular 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)**